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NATIONAL AIDS CONTROL PROGRAMME
INDIA

COUNTRY SCENARIO
AN UPDATE

DECEMBER 1996

NATIONAL AIDS CONTROL ORGANISATION
MINISTRY OF HEALTH AND FAMILY WELFARE
GOVERNMENT OF INDIA

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FOREWORD

In India just in a period of a decade, the HIV infection has spread in all parts of the country. By the end of 1996, of a total of 2.93 million individuals practicing risk behaviours who were screened for HIV, 49527 were found to be sero-positive indicating a sero-positivity rate of 16.3 per thousand. At the same time, a cumulative total of 3161 cases of AIDS have been reported. The actual numbers of both the infected persons and those who have acquired AIDS may be more. The epidemiological data indicate that the prevalence of HIV continues to increase and spread mostly through heterosexual route, from the urban to the rural areas, and from the individuals practicing risk behaviours to the general population. The increasing trends of HIV infection and deaths through AIDS would impact adversely not only on the individuals, households and communities but also on the benchmarks of human development like infant survival, life expectancy, per capita income, school enrolment, health, loss of trained human resource and so on.

The strategic Plan for Prevention and Control of AIDS was put into operation for a country-wide implementation in 1992. The programme has been successful in raising public awareness on HIV/AIDS, community mobilisation and HIV/AIDS education in the formal education system. Comprehensive intervention programmes comprising of HIV/AIDS information and education, condom promotion and treatment of STDs targeted at those practicing risk behaviours have been implemented especially in major metropolitan areas. STD treatment services have been strengthened through training in syndromic management of STD cases. A major achievement has been in the area of blood safety with the implementation of Supreme Court directives of 1996 which instituted mandatory HIV testing in all blood banks. For expanding counselling services, a training project has been launched. Projects in Care and Support have also been initiated in collaboration with NGOs.

Our experience tells us that various strategies put into action are by and large sound. The National AIDS Control Organisation (NACO) however is aware that these strategies may require refinement as we go on implementing them. And the response to the epidemic with its changing scenario need to be considerably expanded in vaious sectors of the society and the government.

This document the Country Scenario 1996 Update, the 4th in the series, presents a comprehensive picture of the challenge posed by HIV/AIDS in India and the response to the epidemic detailing the strategic elements of the National AIDS Control Programme and the activities taking place under the aegis of NACO including the programme highlights of 1996.

I hope the readers of this document would find it useful in many ways. I would welcome any comment or suggestion regarding the contents and the style of presentation of this document which we would use in bringing out the future updates.

J.V.R. PRASADA RAO
Additional Secretary & Project Director
National AIDS Control Organisation.

HIGHLIGHTS OF 1996

- The first meeting of the reconstituted AIDS committee was held.
- Monitoring of NACP based on management information system (MIS) protocol was launched.
- Ministry of Welfare, in collaboration with UN agencies, initiated action to improve STD/HIV/AIDS services in their scheme for the welfare of street children.
- Review of sentinel surveillance system for HIV infection was initiated.
- A meeting of State AIDS Programme Officers was held in Delhi to review the National AIDS Control Programme in the states.
- 18,558 medical officers from various states trained in STD Case Management through Syndromic approach. More than 10,000 private health care providers also trained in STD Case Management by IMA, in collaboration with NACO. Two documents on Syndromic Management of STDs and Treatment Guidelines updated.
- To complement the HIV/AIDS Surveillance, a training module on STD Surveillance formulated for training State AIDS/STD Programme Officers in STD Surveillance.
- In January 1996, a judgement on revamping of blood banking activities in all its facets of collection, testing, quality control, storage, rational use, monitoring, training and research, was delivered by the Supreme Court of India.
- The National Blood Transfusion Council was set up in May, 1996, and the State Blood Transfusion Councils were formed in all the states to regulate blood banking activities. National guidelines on the appropriate use of blood were developed and circulated. To promote donations to the Blood Transusion Councils, the Income Tax Act was revised to provide 100% deduction from gross total income in respect of donations made to the Blood Transfusion Councils.
- Workshops held at Raxaul with eminent personalities including international agencies proposed to identify more cross-border points on the Indo-Nepal border for initiating intervention projects for truck-drivers and other high risk groups on the lines of the Bhoruka AIDS Project.
- A major media blitz was planned for which a private advertising agency was hired for designing a unified multimedia campaign to be implemented in 1997. A full range of IEC materials including posters, stickers, pamphlets, flipcards, wall paintings, TV spots, cinema slides and telefilms have been prepared, some of which has already been put to use.
- To monitor and ensure the quality of telefilms and serials NACO setup an in-house committee to vet proposals submitted by private producers to Doordarshan and to NACO. Proposals for production

of 30 telefilms and 7 teleserials on HIV/AIDS approved, of which 4 telefilms and 3 teleserials telecast.

- An evaluation study of the AIDS awareness activities of the Directorate of Field Publicity (DFP) was initiated.

- NACO directly supported 28 NGOs to implement AIDS awareness activities as well as targeted intervention projects. An IEC package and blueprints of intervention projects based on research, prepared for street children in 4 major cities.

- A Behaviour Sentinel Surveillance Survey was conducted in Tamil Nadu under the AIDS Prevention and Control Project to establish the benchmark. The methodology and findings of the survey will be shared with interested agencies and organizations for future planning.

- Prevention Indicators Survey was conducted in five states. Findings of this survey are of use for the assessment of impact and for future planning.

- A counselling training project for countrywide coverage implemented. A complete training module on "Clinical management of HIV/AIDS at District Level" finalized with particular emphasis on counselling.

- 600 teaching doctors trained on Clinical Management of HIV/AIDS and basics of counselling in 20 workshops conducted countrywide. 429 out of the total 465 districts involved in training their medical officers in Clinical Management, diagnosis and counselling.

- Two workshops on hospital infection control held at Calcutta and Guwahati where 80 trainers were trained. These, in turn, trained over 800 medical officers and health care workers in the states of Kerala, Tamil Nadu, Assam, West Bengal and Karnataka. Training programmes are in progress in other most other states.

EXECUTIVE SUMMARY

Introduction

There has been a relentless spread of HIV/AIDS all over the world over the past few years. Initially restricted to only high risk groups, it has now spread to other strata of society too. A lethal relationship between HIV and Tuberculosis has been observed. TB remains the most prevalent opportunistic infection associated with HIV. This may lead to an increase in the incidence of TB in the general population too. With its wide-ranging impact, HIV/AIDS can lead to various socio-economic imbalances in the community

Though no vaccine is promised in the near future, there is some hope around the combination drug therapy which brings down the viral load in the body, giving a longer symptom-free life to the HIV carriers and AIDS cases. But, at present, it is too expensive a therapy to be considered an option in the developing countries. Other lines of research are also being followed which might yield results later, like the gene therapy and the chemokine therapy. However, in the final analysis, prevention has to be the main strategy to be pursued aggressively involving government and private sector.

Global Overview

With HIV reaching most regions of the world, it has become a global epidemic. The highest prevalence remains in Sub-Saharan Africa, but South and Southeast Asia has shown a remarkably steep increase over the past two years. Adults under 25 years of age and women, in particular, have been found to be more vulnerable to HIV infection. The number of orphans could rise to a staggering two million mark by the year 2000 in Sub-Saharan Africa alone.

Global Response

To counter the onslaught of HIV/AIDS, a global AIDS strategy was developed which was endorsed by the World Health Assembly and the Economic and Social Council of the UN. The three main objectives of this are to prevent infection with HIV; to reduce the personal and social impact; and to mobilize and unify national and international efforts against AIDS.

A new joint programme, UNAIDS, coordinates the responses to the epidemic of its six cosponsoring organizations, viz., UNDP, UNESCO, UNFPA, UNICEF, WHO and World Bank.

Indian Scenario

Considerable increase in HIV prevalence has been observed in the past two years. 49,527 cases of HIV infections have been reported to NACO as on Dec '96. However, WHO estimates 2.5 million infections in India. The infection is spilling over from the high risk groups, earlier considered the reservoir of HIV, to low risk groups and from urban to rural areas through migrant workers and truck drivers. All the states, with the exception of Arunachal Pradesh, have reported HIV prevalence.

India's Response

The National AIDS Control Program (NACP) was launched in 1987 which implemented its Strategic Plan for Prevention and Control in 1992. The aim of the plan was to establish a comprehensive, multisectoral program for the prevention and control of AIDS in India. Seven strategies were identified to achieve the objectives of the plan, which conform to those of Global AIDS Strategy. These are:

i) Program management;
ii) Surveillance and Research;
iii) Information, Education and Communication (IEC) and Social mobilization;
iv) Sexually transmitted Disease (STD) control;
v) Condom Programming;
vi) Blood Safety; and
vii) Reduction of Impact.

Biomedical research in the modern medicine as well as in the Indian systems of medicine is being encouraged by NACO. Social and psychological research is an important input for the implementors towards selection of the most effective approach and adaptation of the strategy to suit the current needs of the time. Prevention Indicators Survey, Behavior Sentinel surveillance survey and High Risk Behavior Survey have proven to be of great importance for the policy makers.

National AIDS Control Program

Programme Management

For effective implementation of the NACP, ensuring efficient management of the program is important. The National AIDS Control Organisation (NACO), established in the Department of Health, Ministry of Health & Family Welfare, is a comprehensive structure at the national level which forges alliance with various ministries and non-governmental organizations, coordinates and monitors the program activities in various states, strengthens the technical and research capabilities and has a system of monitoring and evaluation.

Intersectoral Collaboration

To use the already established extensive network of the government and to seek both greater involvement and commitment of various sectors, links have been established with various ministries, as well as corporate sector. It also increases the reach of NACO to various segments of the society, viz the youth, school going adolescents, women, industrial workforce etc.. NACO also collaborates with various sponsoring and donor agencies, both multilateral and bilateral, as also with NGOs which provides NACO with an established community-based bases of operation.

HIV/AIDS Surveillance

A regular assessment of the magnitude and dynamics of the HIV/AIDS prevalence is vital for the planning. Currently the objective of surveillance is to monitor trends in specific high risk groups and the low risk groups through its 62 sero-surveillance centers functioning with 55 sentinel sites. Efforts are on to determine the trends more accurately by improving reporting, diagnosis of AIDS cases and better case management. Personnel have been trained, sentinel surveillance protocols have been approved and sentinel surveillance sites selected. Fourth round of sentinel surveillance has been completed at 18 sites in 7 states.

Sexually Transmitted Diseases

Since HIV is largely transmitted through sexual route and is related to the same risk behavior the prevention of STDs remains an effective strategy in controlling the HIV transmission. Also, the presence of an ulcerative STD greatly enhances the transmission of HIV. Various intervention projects in India and other African countries have observed stabilization of HIV incidence in the targeted groups where STD treatment services have been provided. STD services in a non-stigmatizing set up, particularly keeping in view the needs of female patients has been the priority. 504 STD clinics have been upgraded and strengthened to provide medical services at the primary health care level. Training of the medical officers and laboratory technicians for better diagnosis and treatment have also been high on agenda.

Condom Programming

Since sexual contact accounts for nearly 75% infections in India, promotion of condom use is the most effective way of preventing transmission. A program was initiated by NACO to make inexpensive, good quality condoms available to the more vulnerable groups through intervention projects and STD clinics. Condoms conforming to WHO specifications only are procured by the government. Social marketing of condoms at a subsidized price has been the policy of the government. All the need of STD/ HIV clinics are met with by the Ministry of Health and Family Welfare.

Blood Safety

There is an overall shortage of blood mainly because of insufficient voluntary donations. However, efficient management of blood and its components through adequate measures for collection, storage and issue, and more importantly, rational use of it could help the situation to some extent. There is a comprehensive programme to modernize blood banks, to establish zonal blood testing facilities for HIV screening and to recruit and train staff to an adequate level. A major thrust to the program came with the Supreme Court Judgement asking the Union of India and States to revamp the blood banking system and to form national/state blood transfusion councils (NBTCs).

IEC

A major component of the prevention and control strategy is to create an informed environment

for people to scrutinize their behaviour and adopt safer practices by raising the awareness and knowledge about HIV transmission and prevention, thus affecting their attitudes and behaviour patterns. NACO is using various channels to reach every vulnerable segment of society, viz., women, youth, adolescents, industrial workforce as well as high risk groups. Specialized packages have been developed so as to influence the target audience and bring about maximum positive impact. Psycho-social research is an important input to the development and implementation of the policies.

Targeted Interventions

Since the major pool of HIV is still the high risk groups such as, commercial sex workers and their clients as also injecting drug users, it is important that concerted interventions be aimed at such groups to prevent further transmission from these groups as also providing adequate health services and counselling to them. Targeted interventions focus on particular groups and offer an integrated set of interventions specific to the needs of that group. Some of the more successful projects are the ones running in Calcutta and Raxaul.

Reduction of Impact

While preventing people from getting infected a support system has been developed by NACP to help the individuals, families and communities absorb the impact of HIV/AIDS. The strategy includes training of counsellors, medical and paramedical staff in AIDS case management and developing a community base care system.

Programme Finance

A remarkable improvement in utilization of funds by states such as Andhra Pradesh, Assam, Himachal Pradesh, Haryana, Gujarat, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Manipur, Mizoram, Meghalaya, Nagaland, Rajasthan, Tamil Nadu, Uttar Pradesh, West Bengal, Delhi and some Union Territories, leading to utilization of 121.31% of the projected utilization for the year 1996-97 has become apparent. However, for want of proper implementation by some states, delay in submission of reimbursement claims, fluctuation in exchange rate of US Dollar vis-a-vis the Indian Rupee, and procedural delays in procurement of equipment for blood banks, blood component separation facilities, and STD clinics, disbursements have been on the slower side.

SECTION I

INTRODUCTION

The crucial challenges faced by any civilization for its survival in the modern era are hunger, sickness and energy shortages. While much has been done in this century to conquer these, we still seem defenceless against the rapid spread of the disease of the century, namely, HIV/AIDS. With its wide-ranging impact, it could well dilute, or even erase, most of our efforts, more so in the case of developing countries, to improve the social and biological health of various communities.

The first cases of HIV infection in India were detected in 1986 and first cases of AIDS in 1987. Since then there has been a steady increase in the number of AIDS cases and a rather rapid increase in the number of persons testing HIV positive.

Initially, the infection was largely endemic to certain groups, such as commercial sex workers, truck drivers and injecting drug users, which routinely indulge in activities that could be termed as high risk behaviours. Typically, these were also the groups which were most closely targeted for HIV studies. However, HIV is now spreading across different strata of society, infecting people not associated with high risk behaviour, in particular, women who are in a faithful, monogamous relationship. Now, with the ramification of testing facilities countrywide, even geographical trends of the spread of HIV are apparent, indicating that the infection is becoming more widespread than believed.

HIV Infection and Tuberculosis

There is an enormous and deadly role that Tuberculosis plays in AIDS epidemic. TB and HIV form a lethal combination, HIV drastically enhancing the potentiality of TB. TB is now the most prevalent, life-threatening opportunistic infection associated with HIV. In India, 61% of AIDS patients have had TB. Given that the annual risk of symptomatic TB is between 5-8% among individuals who are dually infected (i.e., with both HIV and latent TB), increases in new cases of TB seem inevitable. The increased risk is not confined to HIV-infected people only. Those dually infected are capable of spreading the disease to any susceptible individual, leading to a dramatic increase in TB cases among the normal population, too.

HIV and AIDS

The Acquired Immune Deficiency Syndrome (AIDS) is caused by the Human Immunodeficiency Virus (HIV), which affects the immune system of the body to combat infections, disabling it to fight even the commonest of infections. The infection remains latent for 5-10 years before the onset of symptoms of AIDS, however, in children development of AIDS is much faster and is rapidly fatal.

HIV is spread in the following ways:

1. ***Sexual contact**: Unprotected sexual contact between men and women or between men and men is the most frequent mode of transmission of HIV the world over including India. The risk greatly increases with the presence of Sexually Transmitted Diseases.*
2. ***Blood**: Transfusion of blood or blood products contaminated with HIV. Use of needles and syringes stained with HIV infected blood.*
3. ***Vertical Transmission**: HIV can be transmitted from mother to foetus during pregnancy (at about 30% risk), or to the infant during childbirth or during breast-feeding.*

Socioeconomic Impact

The age group which is most affected, i.e., 15-49 years, constituting nearly 89% of all the reported cases, is also the productive and reproductive segment of the society. They are our work force as well as the procreators. They are the ones who are supporting both the generation before and after them. After their premature death, the families will be hard put to sustain themselves. The disruption of the social fabric is not easily quantifiable in both social and economic terms. The scarce health resources will be further strained as more and more people reach the stage of AIDS and require medical care. Since HIV prevalence is higher in the marginalized or stigmatized groups of society, such as commercial sex workers, injecting drug users, truck drivers, etc., their orphans are likely to become street children. There will be further increase in child delinquency and poverty. No other disease affects marital harmony, human rights, employment security and family economy of those affected as does HIV/AIDS.

Advancement in Medicine

Although a vaccine against AIDS is still not in sight, yet there is some optimism about the combination drug therapy which brings down the viral load in blood and lymphoid tissue to untraceable levels, thereby giving a longer symptom free life to those infected. A combination regimen of three drugs - Zidovudine (AZT), 3TC and protease inhibitors (Norvir, Saquinavir, Indianavir) - brings down the viral load in the system. However, it is not yet tested whether the low levels of virus will be maintained after the therapy is withdrawn. Although these drugs have shown encouraging results, because of their prohibitive cost, it is not really a viable option for most people in developing countries.

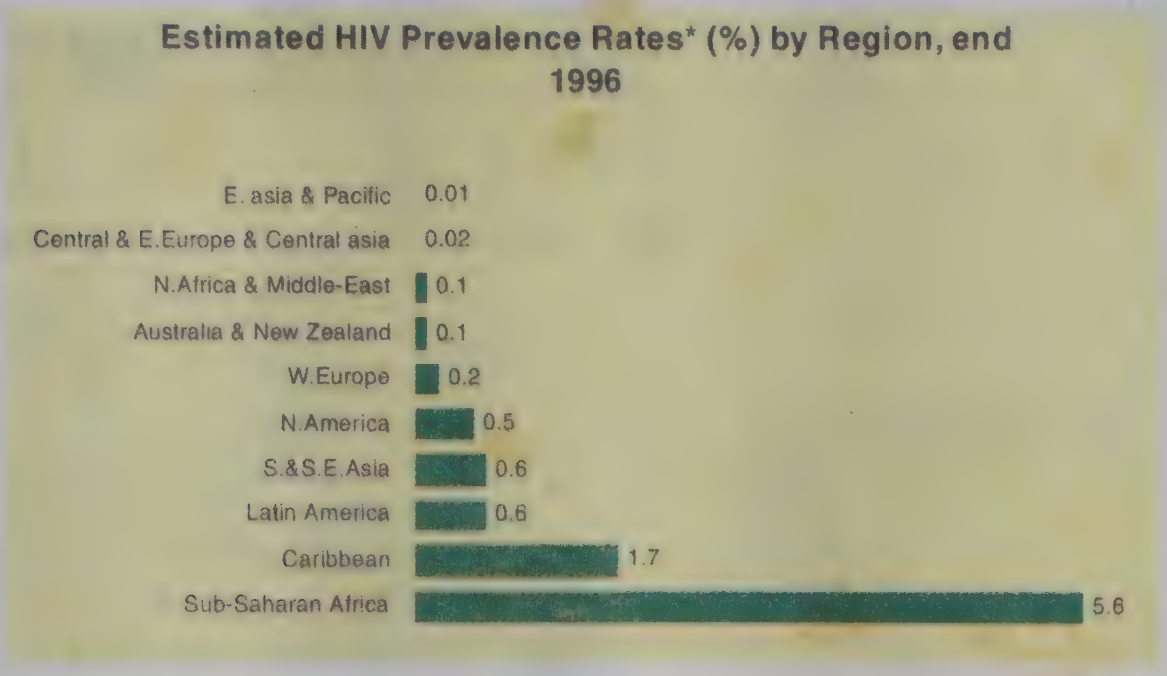
Amongst the new approaches, the scientists are more hopeful about the prospects of gene therapy which could possibly make the immune system impervious to HIV attack. Another promising line of research centres on a group of molecules called chemokines which may be used one day to shield cells from HIV.

The Task Ahead

The number of AIDS cases reported in India so far is only 3161 (as on December, 1996), but HIV prevalence is high. Since the infection remains latent for a long time and the carriers of HIV appear normal for 5-10 years between the initial infection and reaching the symptomatic stage of AIDS, the impact of HIV as an epidemic is not yet fully visible in India. HIV awareness and prevention programs must start well in advance of the stage when full blown AIDS cases, in multitudes, start reporting sick at the health care centres at various levels. It will be a great burden on our health services which are already overworked on account of the more immediate problems like diarrhoea, malaria, tuberculosis, etc. We must use all our resources and every conceivable idea to prevent further HIV transmission now, while gearing up our health services for the future. A careful planning and most judicious channelling of our resources is required in order to contain further transmission, for prevention is the only hope for developing countries.

GLOBAL OVERVIEW

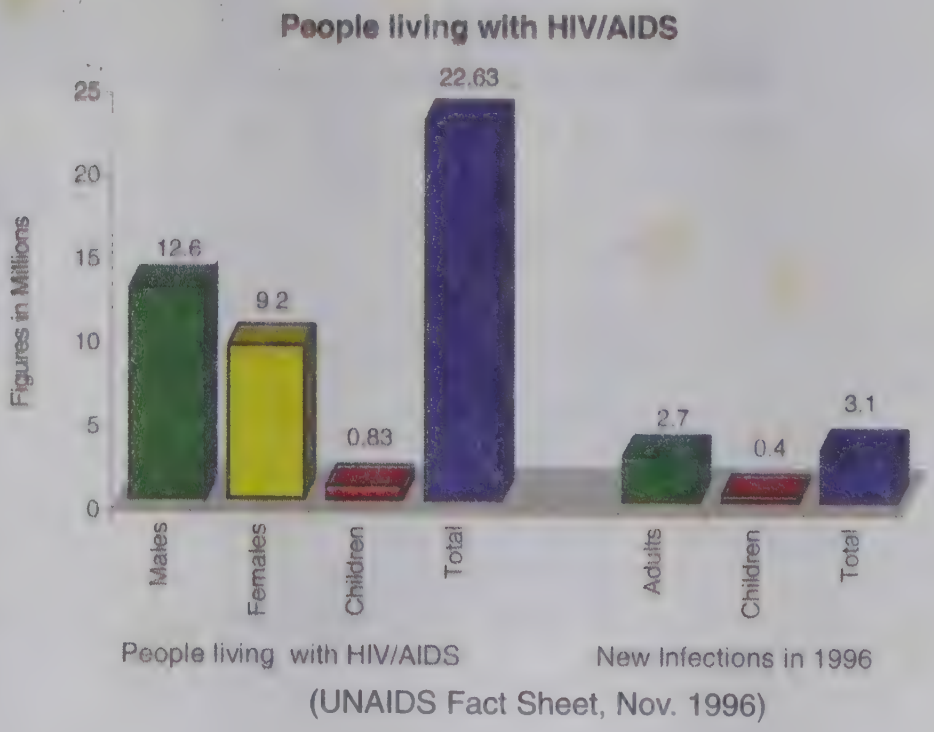
HIV made sluggish inroads into North America, West Europe and Australia in the early 1980s with HIV registering its presence in the USA in 1981 when the first case of AIDS was reported. Gaining momentum in the late 1980s, HIV had reached most regions of the world with reports of high prevalence coming from South America, sub-Saharan Africa and the Caribbean. Now, in 1996, while high figures of HIV prevalence are pouring in from the world's second most populous region, i.e., South and Southeast Asia, new populations in Central and East Europe and Central Asia are also reporting HIV infections. HIV/AIDS has now become a truly global epidemic with an estimated 22.6 million people living with HIV/AIDS, including 3.1 million new infections in 1996 alone.



*HIV Prevalence rate equals the number of persons living with HIV/AIDS in a specific region at a specific time divided by the total population of the region. (UNAIDS Fact Sheet, Nov. 1996)

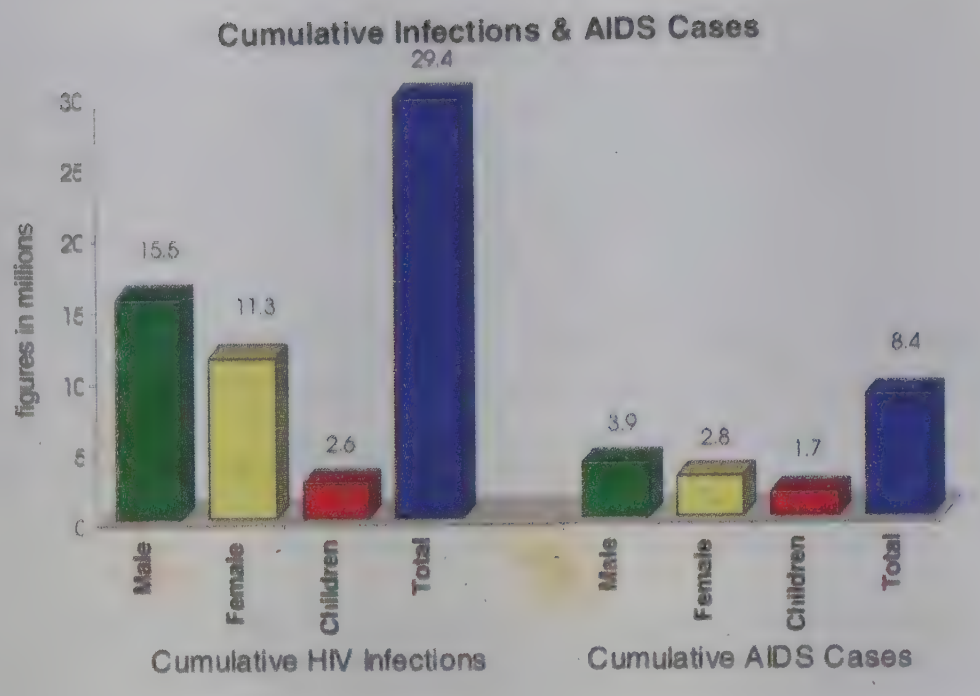
Some other observations are:

- Majority of the 2.7 million newly infected adults are under 25 years of age.
- Around 50% of the new infections now occur in women.
- There were 400,000 new infections among children in 1996, bringing the total number of children living with HIV/AIDS to 830,000
- A New York-based orphan project estimated that nearly 1 million children under 14 years of age have been orphaned by AIDS in Kenya, Rwanda, Uganda and Zambia, which may rise to 2 million by the year 2000.



(UNAIDS Fact Sheet, Nov. 1996)

As per UNAIDS projections, there have been 29.4 million cumulative HIV infections so far, worldwide, of which 2.6 million are children. Sub-Saharan Africa continues to be the most affected region accounting for 14 million of the total HIV infections. This is followed by South and Southeast Asia, with a total of 5.2 million infections. Of the 8.4 million cumulative AIDS cases in the world, 1.7 million happen to be children.



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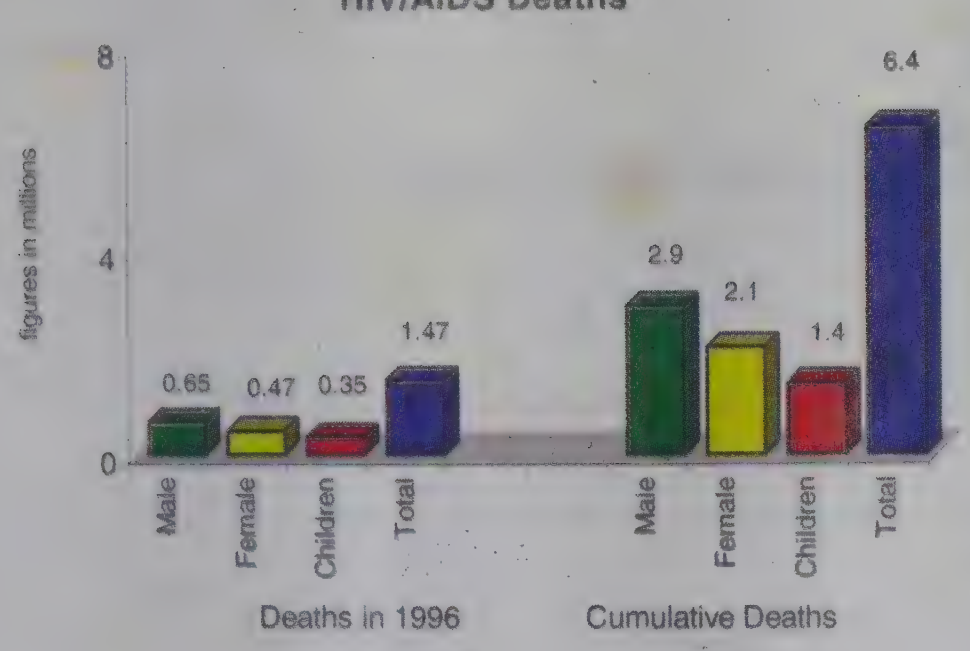


(UNAIDS Fact Sheet, Nov. 1996)

For the year 2000, the current WHO projection is that there will be a cumulative total of about 40 million HIV infections of which 90% will be in the developing countries. The epidemic is expanding rapidly in South and South East Asia and will soon surpass Africa in the annual number of new infections. Asia is projected to have 8 million HIV infections. The cumulative number of HIV related deaths in adults is predicted to rise to more than 8 million from its current total of 6.4 million. In 1996 alone, there were about 1.1 million AIDS deaths among adults.

ESTIMATED DISTRIBUTION, AS OF MID 1996, OF ADULTS AND CHILDREN INFECTED WITH HIV
SINCE THE LATE 1970S
(GLOBAL TOTAL: 27.9 MILLION*)

(UNAIDS Fact Sheet, Nov. 1996)

GLOBAL RESPONSE

The Global AIDS Strategy

The initial global AIDS strategy designed in 1985-86 was reviewed in 1991 to reflect scientific advances and practical experience gained in the interim. The new strategy endorsed in 1992 by the World Health Assembly and by the Economic and Social Council of the United Nations, proposes ways of meeting new challenges of the evolving epidemic, which include:

- adequate and equitable provision of health care to the growing numbers of HIV-infected people falling ill;
- treatment for other sexually transmitted diseases, which increase people's vulnerability to HIV infections;
- reduction of women's social vulnerability to HIV infection by improving their health, education, legal status and economic prospects;
- a more supportive socioeconomic 'environment' for AIDS prevention;
- immediate planning in anticipation of the pandemic's socioeconomic impact;
- a greater focus on conveying effectively the compelling public health rationale for overcoming stigmatization and discrimination.

The three main objectives of the strategy remain:

1. to prevent infection with HIV;
2. to reduce the personal and social impact of HIV infection
3. to mobilize and unify national and international efforts against AIDS.

UNAIDS

The global strategy was initially coordinated by the WHO Global Programme on AIDS, which was setup in 1987. In 1996 this was replaced by a new joint programme, UNAIDS, which is cosponsored by UNDP, UNESCO, UNFPA, UNICEF, WHO and the World bank. UNAIDS both coordinates the responses to the epidemic of its six co-sponsoring organizations and supplements these efforts with special initiatives. Its purpose is to lead and assist an expansion of the international response to HIV/AIDS on all fronts: medical, public health, social, economic, cultural, political and human rights. UNAIDS works with a broad range of partners - governmental and non-governmental, scientific and lay - shares knowledge, skills and best practice across boundaries.

India is one of the 22 member states represented on the programme coordinating board, which acts as the UNAIDS governing body on programme issues concerning policy, strategy, finance, monitoring and evaluation.

Global Developments

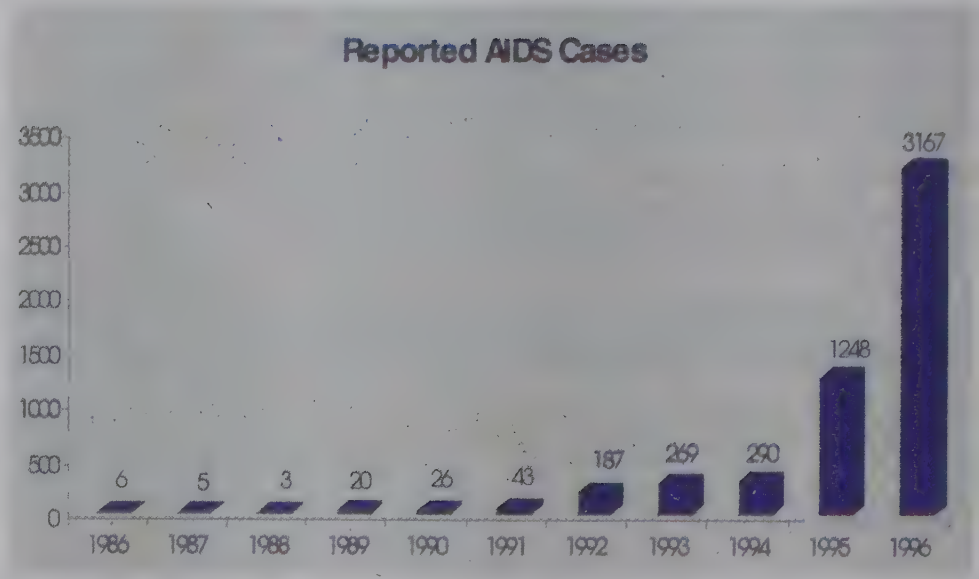
Despite the efforts to slow the spread of HIV infection, the HIV/AIDS pandemic has now become truly global, as only a few areas in the world remain untouched. It is estimated that effective HIV prevention in developing countries could reduce the number of new adult infections in the remainder of the decade by 9.5 million, or by approximately 50%. Although a number of candidate vaccines are currently in phase III human trials, a potent vaccine may not become available to us in near future. However, much optimism hinges on the combination drug therapy which, if successful, could considerably enhance the longevity of the HIV carriers by keeping them asymptomatic for longer time.

Strategies for the prevention of HIV infection in prisons have been developed and are being implemented in a number of countries. The vulnerability of women to HIV infection and AIDS has been recognized, and the strategies to reach women are being incorporated in prevention strategies in many countries. Sex education in schools has been identified, and studied as one of the few options to protect as yet uninfected youth from infection.

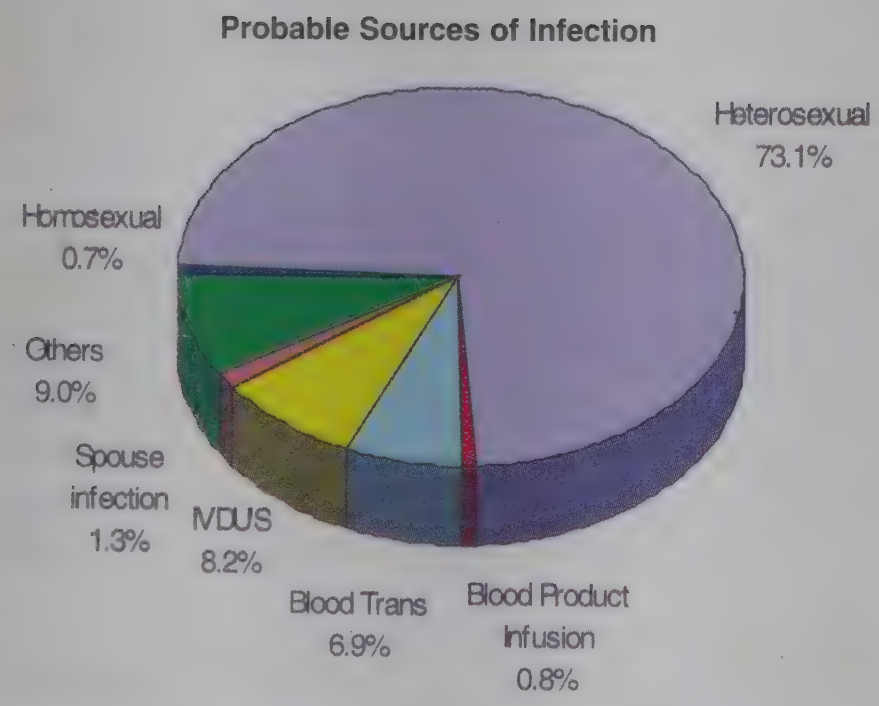
Lastly, the vital importance of the protection of the human rights of people with HIV infection or AIDS and the prevention of discrimination is once more underscored. Discrimination against people with HIV/AIDS still impedes efforts of prevention of HIV infection in many countries. A more detailed description of global developments and global responses is contained in Annex One.

INDIAN SCENARIO

India has seen a considerable increase in the number of people living with HIV/AIDS, particularly over the past 2 years. WHO currently estimates 2.5 million HIV infections in India . As reported to NACO, there are 49,527 HIV infections (cumulative till Dec '96), with sero-positivity rate of 17.0 per thousand. The number of AIDS cases reported are 3,161. Although there has been improvement in the detection and reporting of AIDS cases, these figures may still underestimate the true cumulative prevalence of the infection. Some of the trends observed are:



(Epidemiological Report, Dec. 1996, NACO)



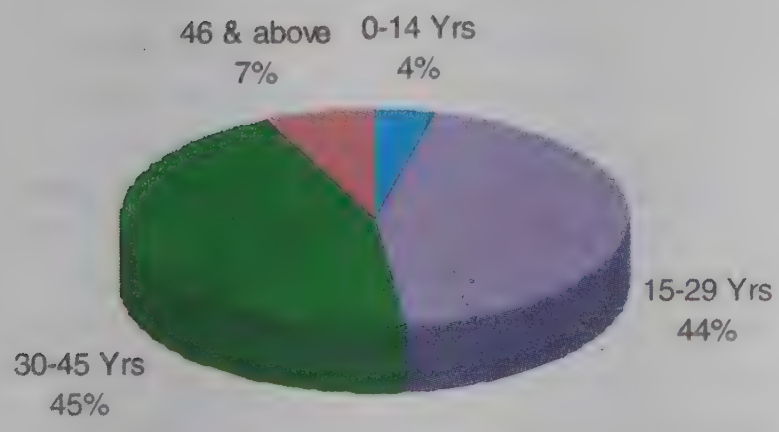
(Epidemiological Report, Dec. 1996, NACO)

- Heterosexual contact is still, by far, the most prevalent mode of transmission.
- Increasing sero-positivity rate has been found among injectable drug users in the North-eastern states of India, particularly in Manipur and Nagaland.
- 77% of the AIDS cases are males, while only 23% are females.
- About 1% of the total HIV cases are antenatal mothers who are considered as `low risk group'.
- There is incidence of HIV among women who are in a faithful relationship with their husband, earlier considered as `low risk group'.
- Higher HIV prevalence has been found along major truck routes.
- Migrant workers and transport facilities have increased the chances of spread of HIV across the country and from limited urban pockets to the vast countryside.

The above observations are indicative of the spillage of HIV from high-risk groups to other

strata of general population too. While Maharashtra has reported highest number of both HIV and AIDS cases, Arunachal Pradesh is the only state to have reported zero sero-positivity.

Age Distribution of AIDS Cases



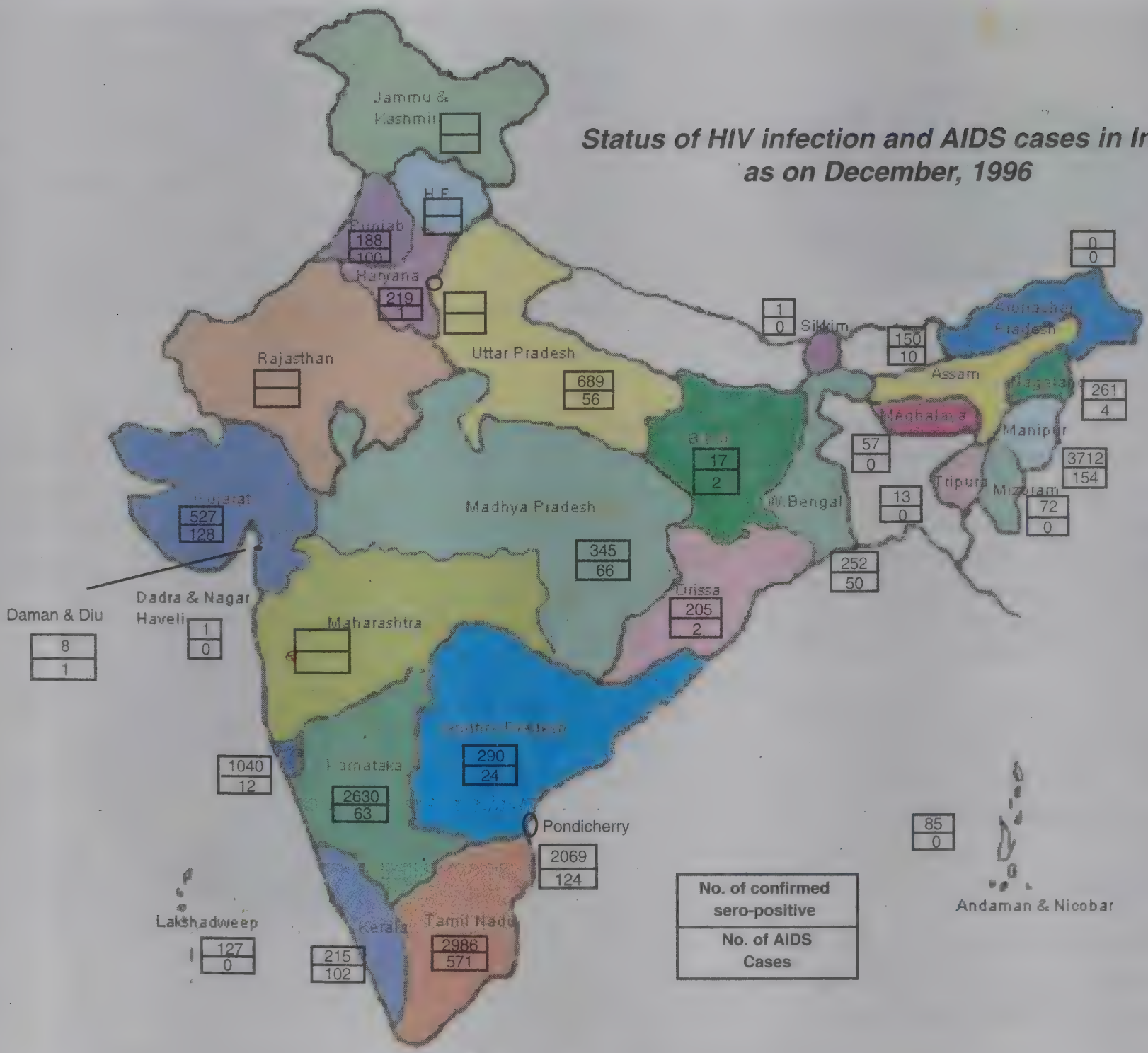
(Epidemiological Report, Dec. 1996, NACO)

Impact

The increased mortality among adults and children has raised concerns that AIDS may become so devastating as to reverse positive population growth rates and wipe out entire populations. In December, 1989, WHO, in conjunction with UN Population division used six mathematical models to examine the demographic consequences of the AIDS pandemic. In a population with a 3% growth rate modelling, showed that a negative growth rate would result only when HIV prevalence in the entire population exceeded 40% - a level not seen in any general population so far.

Since the age group most infected is 15-49, it is going to adversely affect various demographic ratios. Our limited health resources will be at a great strain to deal with all the AIDS cases. Vulnerability of women to the pressures of AIDS is a major area of concern as observed in Manipur as well as Mumbai. A study conducted in Mumbai by Tata Institute of Social Sciences (TISS) shows that women are already experiencing the burden with having to take care of the AIDS affected husband while they themselves have failing health on account of the infection they contracted from their husbands. Future security of their children after their death remains an unresolved problem for most of them.

HIV/AIDS IN INDIA



INDIA'S RESPONSE

After the detection of the first case in India, the Government of India constituted a National AIDS Committee in 1986. The very next year the Government, with assistance from WHO and other multilateral and bilateral donors, mounted a response to the epidemic. In the initial phase, activities were largely focused on HIV screening of the so called `sexually promiscuous groups' and blood donors.

In 1989, with support from WHO, a medium term plan from AIDS control was developed with a US $ 19 million budget to be provided from external sources. Project documents for the implementation of this plan were developed and implemented in 5 states and UTs which were most affected, namely Maharashtra, Tamil Nadu, W. Bengal, Manipur and Delhi. Initial activities focused on the reinforcement of programme management capacities as well as targeted IEC and surveillance activities. Actual preventive activities like implementation of educational and awareness programmes, blood safety measures, control of hospital infection, condom promotion to prevent HIV/AIDS, strengthening of clinical services for both STD and HIV/AIDS gained momentum only in 1992. Surveillance and prevention activities in the rest of the country were planned in consultation with Governments of States and Union Territories. Ever since, there has been significant improvement in awareness and adoption of preventive practices, especially among the high risk groups. Implementation of multi-pronged interventions targeted at specific groups have proven to be particularly effective in controlling the rate of transmission.

Strategic Plan 1992-1997

In 1991, a number of donors indicated their interest to support India and accordingly a "Strategic Plan for Prevention and Control of AIDS in India" was prepared for the five year period of 1992-1997. The Strategic Plan has to date received support from the World Bank, WHO and other international agencies for approximately half of the Plan's programme. The aims of the plan were to establish a comprehensive, multisectoral programme for the prevention and control of AIDS in India which would:

- prevent HIV transmission
- decrease the morbidity and mortality associated with HIV infection
- minimize the socioeconomic impact resulting from HIV infection.

These goals were to be achieved through meeting a series of medium term objectives:

- To establish effective surveillance in all states to monitor the epidemic.
- To provide sound technical support.
- To ensure a high level of awareness of HIV/AIDS and its prevention in the population.
- To promote the use of condoms.
- To target interventions at groups identified as high risk.
- To ensure the safety of blood.
- To develop the services required to provide support to HIV infected persons, AIDS patients and their associates.

Seven strategies were initially defined to meet these objectives:

1. Programme management
2. Surveillance and Research
3. IEC and social mobilization
4. STD Control
5. Condom programming
6. Blood safety
7. Reduction of impact.

As the epidemic acquired larger proportions, many facets of its impact became more evident The increased vulnerability of women to HIV/AIDS and promotion of human rights and ethics in HIV AIDS prevention and care, in particular, were taken cognizance of and new approaches were formulated and strategies adapted accordingly. The above mentioned components are discussed in greater detail in the following chapters.

Research Programmes

Since HIV/AIDS has far reaching implications for the communities, research on every aspect of the impact it can have is imperative. While research into medicine is important to find a cure to save millions of lives of the infected, research in social, psychological and behavioural aspects could contribute more immediately to the current Control and Prevention Programme as also help the families and communities cope with the pressures of taking care of those already infected and those with AIDS.

Biomedical research

Between 1992 and 1994, bio-medical research proposals were invited on an ad hoc basis, to be submitted to the NACO research subcommittee for approval. Two research projects, one on HIV and Tuberculosis, the other on opportunistic infections, were completed during this phase. In December 1994, NACO's research subcommittee resolved to identify specific areas of research and the investigator - sponsored research projects - which NACO would fund. The research subcommittee has also supported the provision of a number of grants to post-graduate students whose theses have a direct bearing on prevention and control of AIDS and HIV.

Systems of Indian Medicine and Homeopathy

The Indian Council of Medical Research (ICMR) is coordinating research into Indian systems of medicine and Homeopathy. A committee has been constituted under the chairmanship of the former director of the Central Drug Research Institute, Lucknow. A protocol has been developed for research proposals, which are submitted to and processed by the ICMR. ICMR has constituted a committee to consider the claims and counter-claims of different systems of medicine, including Homeopathy. They have examined all the proposals and have asked to send in their respective plans in a fixed protocol

prepared by the ICMR. Accordingly, only Ayurved, Siddha and Homeopathic institutions have submitted the preliminary report plan of their research.

Social and Psychological Research

Almost all of the control and prevention efforts, in one way or the other, seek to change the behaviour patterns. Research into attitudes towards sex and sexuality, current status of knowledge, people's responses to health promotion messages, and their practices can help to ensure that the programmes formulated are effective on implementation. The national **High Risk Behaviour Survey,** the **Prevention Indicators Survey**, a qualitative and quantitative survey regarding perception of condom and its usage and the **Behaviour Sentinel survey** done on an annual basis are a few efforts which have helped in the strategy formulation. These surveys are described in greater detail in the following chapters.

SECTION II

PROGRAMME MANAGEMENT

Highlights of 1996

- National Aids Committee was reconstituted and its first meeting held in Delhi.
- A meeting of the state AIDS programme officers was held in Delhi to review the National AIDS Control Programme (NACP).
- Monitoring of NACP based on management information system (MIS) protocol was launched.

Introduction

In order to accomplish the objectives of the National AIDS Control Programme, efficient programme management constitutes one of the most significant components of the overall Programme. Establishing an effective mechanism for inter-sectoral collaboration, strengthening of technical and research capabilities, enhancing programme managerial capability, efficient flow of funds and an inbuilt mechanism for monitoring and evaluation are some of the highly relevant management needs of the AIDS Control Programme. Taking these needs into account, due emphasis has been accorded to the component of programme management.

Objectives

The broad objectives of this programme are as follows:

a) Establishment of an effective programme management mechanism at the national and state levels;
b) Provision of technical, financial and operational support to the staff and organizations implementing programme activities.

These objectives are addressed through four major strategies outlined below:

1. The Creation of Intersectoral collaboration for AIDS Control and the Mobilization of Opinion Leaders.

Keeping in mind the earlier management infrastructure available both at the national as well as state level, a number of management/coordinating bodies have been constituted at the union and the state levels in order to ensure effective programme management.

In May, 1992, the National AIDS Control Organization (NACO) was officially created as the executive governmental organization to oversee AIDS prevention and control efforts in India. The NACO is supported in its task by a Multisectoral Committee and a National AIDS Control Board as well as various specialized advisory committees. Likewise, each State and Union Territory has set up similar

multisectoral empowered committees as well as executive programme bodies to develop and implemen AIDS prevention and control activities at the State/Union Territory level.

According to the strategic plan, the Government of India, Ministry of Health and Family Welfar has constituted a National AIDS Committee (NAC) under the chairmanship of the Union Minister o Health and Family Welfare with representatives from various sectors.

This forum has been formed to bring together various ministries, non-governmental and privat voluntary organizations with a view to coordinate the Programme's activities. The Committee acts a the highest level deliberative body to oversee the performance of the Programme and to provide th overall policy directions. The Committee is also entrusted to forge multisectoral collaboration to enabl the participating organizations to mobilize their own administrative network for various HIV/AIDS prevention projects.

The Committee has been reconstituted and its first meeting was held in Delhi on 26 March '96.

Multisectoral Committee

The Government of India has constituted a Multisectoral Committee under the chairmanship o Secretary (Health) to assist in the development of a coordinated policy to prevent and control the sprea of HIV/AIDS. The Committee decides on the strategies and mechanisms of such coordination and meet as frequently as required.

2. Development of an Efficient Mechanism for Programme Coordination and Management a both National and State Levels.

National Level

(a) National AIDS Control Board

A National AIDS Control Board has been constituted at the national level under the chairmanshi of Secretary (Health) in order to approve NACO policies, to expedite sanctions, approve procuremer and to undertake and award contracts to private agencies. The other major functions of the Boar pertain to the approval of annual operational plan budgets, reallocation of funds between programm components, formation of the programme managerial teams and appointment of senior programm staff.

The Board exercises all financial and administrative powers which are beyond the powers of th NACO and which the Department of Health, Government of India can exercise with the approval of th Department of Expenditure, Ministry of Finance. No separate reference to Ministry of Finance for fundin planned activities is required as the Ministry of Finance is represented on the Board.

The National AIDS Control Board has also been entrusted with all the functions which hitherto were being performed by the Technical Advisory Committee under the chairmanship of the DGHS.

The Board meets quarterly or more frequently as may be required by the Chairman of the Board or Director of the National AIDS Control Organization. The organizational structure of the National AIDS Control Programme is shown in the figure on page 18.

Since its constitution, ten meetings have been held. Issues discussed and decided upon at the tenth meeting, held in July'96, were among others; control of hospital infection through installation of incinerators in hospitals and medical institutions in conformity with the supreme court judgement and the Central Pollution Control Board be addressed by NACO to lay down the standards for incinerators; establishing a health line called Sparsh in consultation with the World Bank ; installation of condom vending machines; purchase of educational material from private sources; and truck drivers intrevention for STD/HIV/AIDS awareness in Delhi-Jammu and Delhi-Kanpur Highways.

(b) National AIDS Control Organization

In order to combat the onslaught of the AIDS epidemic effectively, an exclusive separate wing comprising a dedicated staff has already been established under the Department of Health, Ministry of Health and Family Welfare. The organization is headed by a Project Director, ex-officio Additional Secretary to the Government of India, who is being assisted by technical and administrative staff including a Technical Officer (Addl Project Director) at the Joint Secretary level. The Organization exercises all financial and administrative powers as vested in the Department of Health, Government of India. The headquarters of the NACO, previously located at the Red Cross building, New Delhi, has now been shifted to Nirman Bhawan, New Delhi, with effect from October, 1996.

3. Strengthening Programme Managerial Capacity at the State Level.

In order to strengthen the programme management at the state level, the state administrations have established their own managerial bodies which include State AIDS Cells, Technical Advisory Committees and Empowered Committees as per the guidelines of the Strategic Plan. The structures of the State-level AIDS Cells are shown in figure on page 19. Progress in the development of state management teams has been satisfactory, although some states have responded more effectively than others so far.

(a) Empowered Committee

At the state level, an Empowered Committee has been constituted by the States either under the chairmanship of Chief Secretary or Additional Chief Secretary at par with the National AIDS Control Board.

This committee makes the policy decisions for implementation of the AIDS Control Programme in the respective State and approves administrative and financial actions which otherwise would have

been approved by the State Department of Finance.

(b) State AIDS Cell

A separate cell in the Directorate of Health Services of the states has been formed in all 32 states/UTs. In the larger states, this Cell is headed by a State AIDS Programme Officer at the level o Additional Director. In the smaller states the Cell is headed either by a Joint Director or a Deputy Director The State AIDS Programme Officer is supported by other staff in the key programme areas of IEC Sexually Transmitted Disease, Surveillance and Blood Safety. The Cell is responsible for the day-to-day monitoring and supervision of the programme in each state.

4. Monitoring and Evaluation of the NACP

Monitoring

With a view to monitor the various activities in the NACP effectively and regularly, a set o monitoring indicators were developed based on WHO guidelines in the second half of 1994. After field testing, the MIS protocol was finalized and a detailed action plan was chalked out to prepare an outline for developing a system of monitoring in all States and Union Territories of the country. For furthe implementation of this monitoring system a training module was also developed for use by State AIDS Cells.

Two national workshops on monitoring of AIDS Control Programme were held in May 1996 where all State AIDS Programme Officers and one official each from State AIDS Cells were trained. I these workshops an action plan was drawn by state officials for training of other officials of State AIDS Cells and District Focal Officials responsible for implementation of the NACP. After the training is over a mechanism of information system based on Management Information System (MIS) protocol will b developed at the State AIDS Cells so that the programme could be monitored regularly.

Evaluation

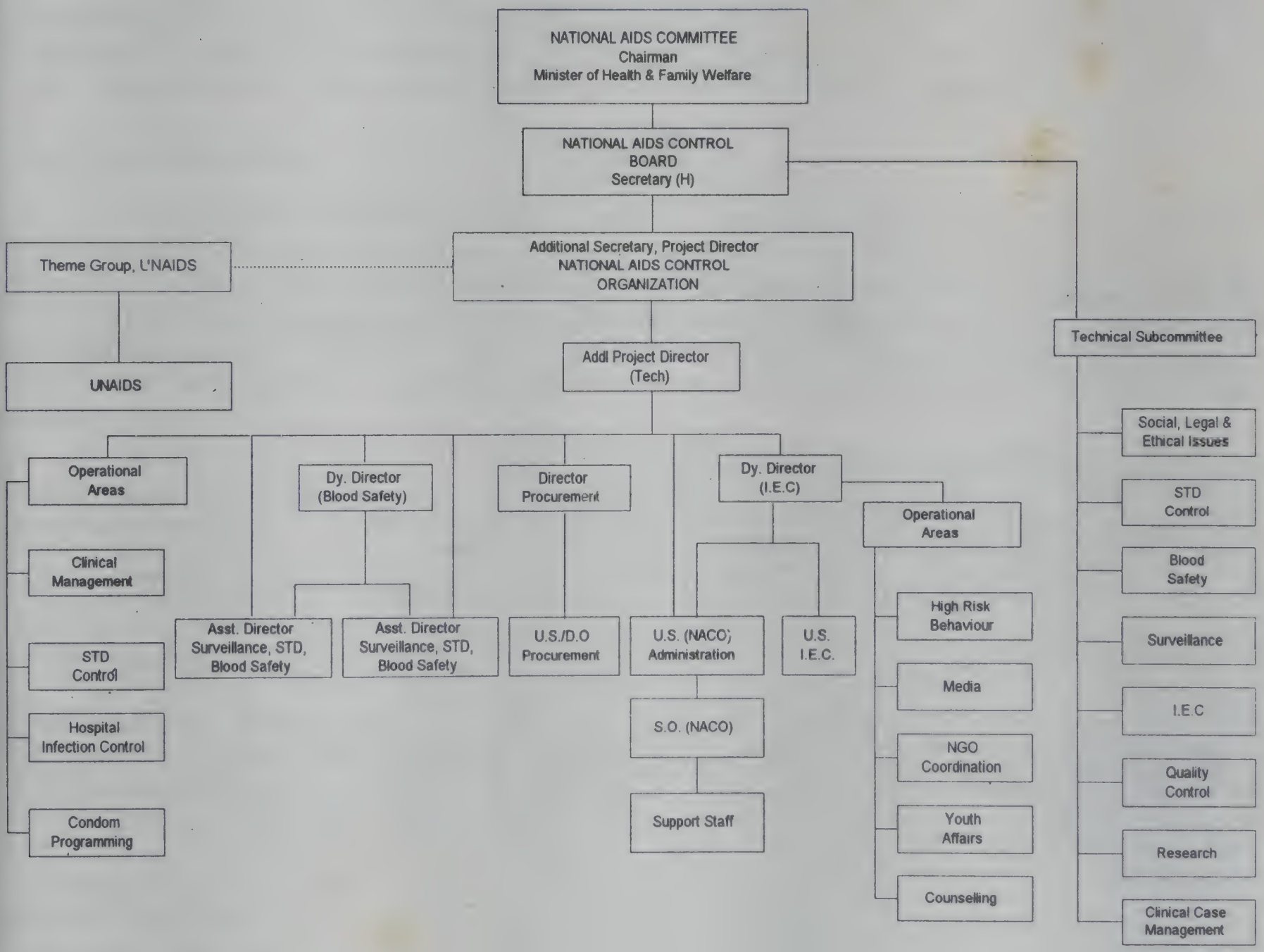
In 1992, the NACP commenced in a comprehensive manner with financial assistance from th World Bank and technical inputs from the WHO. In 1995, after the completion of three years of thi project, a need to evaluate this programme was felt with two objectives. Firstly, to assess the achievement made so far, and, secondly, to identify the gap areas where there is a need to build up further.

In order to evaluate the NACP, a set of ten prevention indicators (PI) have been developed b WHO. The indicators were designed with the objective of measuring achievements in respect of knowledg about preventive practices, availability - accessibility - actual use of condoms, quality of STD car management facility and reduction in the incidence of STD.

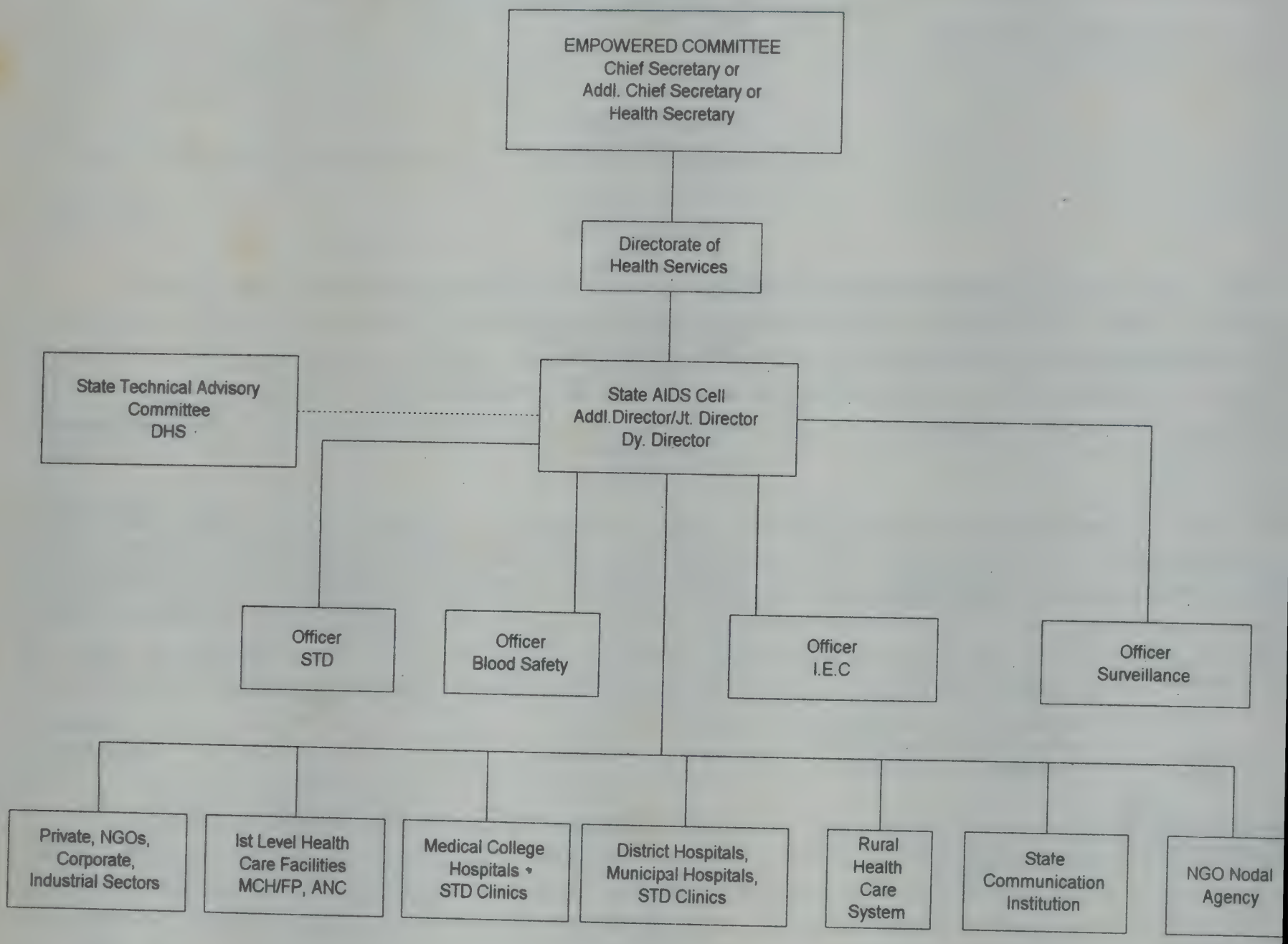
This evaluation, called the **Prevention Indicator (PI) Survey**, was taken up in 5 states, viz Maharashtra, Tamil Nadu, west Bengal, Delhi and Haryana. The survey includes both the populatio

survey and the STD health facility survey in urban areas and population survey in rural areas (except those in Delhi) in these identified states. All states have completed the survey and submitted the reports to NACO. The final document on PI Survey is under preparation in NACO based on the reports received from these 5 states.

Organizational Structure of the National AIDS Control Programme



Organizational Structure of the State AIDS Control Programme



INTERSECTORAL COLLABORATION

Highlight of 1996

- Ministry of Welfare in collaboration with UN agencies initiated action to improve STD/ HIV/AIDS services in their scheme for welfare of street children.

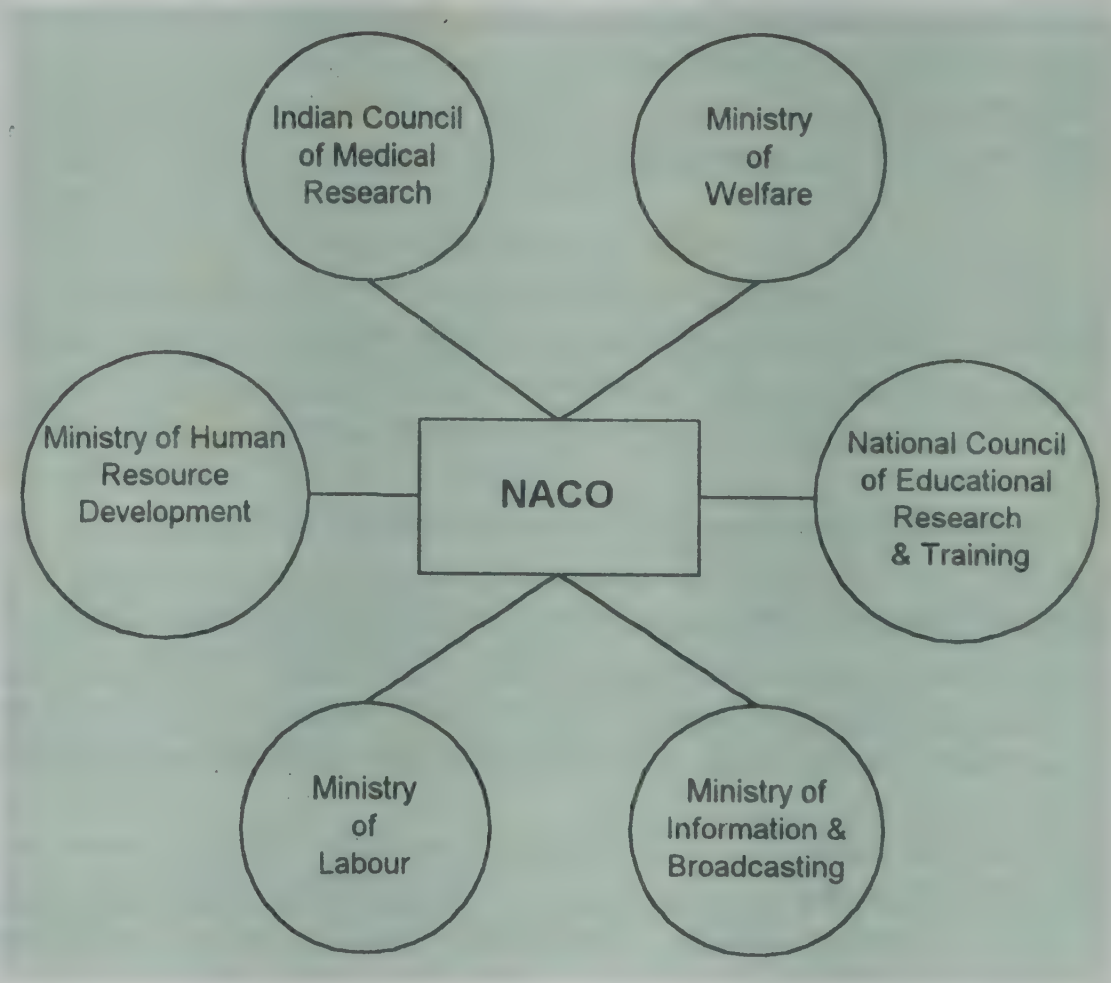
The challenges posed by HIV/AIDS have implications far beyond the health sector and spill into many other sectors , therefore, the responses to these challenges must encompass the broadest base possible throughout the public and private sectors of society in India. Recognizing this fact, the National AIDS Control Organization seeks to enlist and encourage the involvement of every possible actor, public or private, large or small, in the fight against HIV/AIDS/STD in India.

Multisectoral Committee

The formation of the Multisectoral Committee, which has representatives from most major government ministries and departments, has been described in the previous chapter on Programme Management. As a consequence, all Union Ministries and Departments which could have any conceivable link with NACO and its programme have been invited to identify focal points in their Ministry/Department who will serve as the responsible officers for the development of Ministerial/Departmental plans of action in the battle against this new challenge. Similar steps are envisaged at State and Union Territory Government level.

Collaboration within the Government of India

The collaboration of various ministries with the NACO are shown in the figure below. In addition to this, all Government Ministries/ Departments with activities related to the general programme of HIV/AIDS/ STD prevention and control have been requested to identify a nodal officer to be responsible for the coordination and development of that Ministry/Department's activity plan in collaboration with NACO. A total of 29 Nodal officers have been identified, and plans are underway to assist each with the setting-up of their action plans.


Indian Council of Medical Research
Ministry of Welfare
Ministry of Human Resource Development
NACO
National Council of Educational Research & Training
Ministry of Labour
Ministry of Information & Broadcasting

Another means by which NACO attempts to ensure the sort of coordination of efforts and resources required in this struggle is through periodic meetings of all "interested" or "participating" parties who are already involved in or interested in becoming involved in the prevention and control of HIV/AIDS/STD in India. These meetings continue to provide an opportunity for NACO to highlight recent programmatic developments and progress in the fight against HIV/AIDS/STD, while at the same time affording other parties (bilateral and multilateral donors, NGOs or other Governmental Departments or Ministries) the opportunity to discuss the national programme's direction and priorities. In 1996 meetings were held with all the media units of the Ministry of Information and Broadcasting to review the implementation of awareness campaign, with para-millitary forces to identify training and IEC material needs, with Railways to identify project needs and with the Department of Youth Affairs to identify the future programme activities for the youth.

Multilateral/bilateral Agencies

UNAIDS - The joint United Nations programme on HIV/AIDS - UNAIDS - brings together and coordinates six UN agencies (UNICEF, UNDP, UNFPA, UNESCO, WHO and the World Bank) in a common effort to fight the epidemic. The World Health Organisation (WHO) has provided policy leadership, technical assistance and financial support to HIV/AIDS prevention and control activities in India. Long- and short-term national and international consultants have also been recruited by WHO to provide additional technical advice and expertise to the country. The major activities of the UNAIDS Theme Group in India in the year 1996-97 are summarised below:

Strategic Area/Activity	Outcome Indicators	Lead Agencies
National AIDS Control Project:	-Support to programme management, -Transmission through blood prevented; -Availability of STD services, and awareness about prevention methods and reduced STD incidence -Behaviour change brought through IEC and communities mobilised; condom usage increased -Care and social support provided for HIV infected and its impact well managed by families and communities; HIV/STD/AIDS trends monitored through more accurate Surveillance	NACO World Bank Key partners: WHO, UNAIDS
Street Children Project	-Risk taking behaviour related to drug abuse, HIV/AIDS/STD amongst street children -Communication package distributed and strategies developed to reduce risk to street children	UNDCP UNICEF
National Population Education Projects in formal education system	-Effective integration of adolescence education package on HIV/AIDS/drug abuse into revised curriculum framework; teacher training; compulsary course in colleges	UNFPA

	& universities; support to counselling services	
UNFPA Area Project, Haryana & Himachal Pradesh	-Integration of STD/HIV/AIDS in training manuals of Sanjeevnis/adolescent girls.	UNFPA
Support to Universities Talk AIDS Programme	-6 UNVs assigned to programme to strengthen technical assistance on community mobilisation and HIV/AIDS	UNDP
School Education Proposal	-Review and analysis of pilot school HIV/AIDS projects with national and state ministries of education, health with a view to expanding HIV/AIDS activities in schools.	UNESCO UNFPA UNICEF
School Education	-Adapt training manuals, reference material on HIV/AIDS education to be used by teachers. -Teacher training on HIV/AIDS at district level.	UNESCO

Bilateral Donor Agencies

Assistance to national and state level efforts to prevent and control the spread of HIV/AIDS/STD have also found encouraging support amongst the local bilateral donor community. Highlights of the major contributions made and planned are as follows:

- The Swedish International Development Authority (SIDA) – Sweden has contributed almost 1.5 million US Dollars (through WHO) to India, most of which was earmarked for an STD/HIV intervention project in Mumbai. In addition, SIDA is also providing direct support to NGO project proposals for HIV/AIDS prevention and control activities in the Northeastern states and has supported the creation of a training and resource team for NGOs from these states.

- The US Agency for International Development (USAID) – A US $ 10 million project in support of NGO-based and implemented HIV/AIDS/STD prevention and control activities in Tamil Nadu (APAC Project), is under way. The project, which commenced in February 1995, will continue for seven years. Activities funded under this focus primarily on the IEC and condom promotion.

- The Norwegian Agency for Development (NORAD) – In addition to extensive support to NGO activities throughout the country, NORAD has supported since November 1992 an STD/HIV intervention project in a red light area in Calcutta, coordinated by the All India Institute of Health and Public Hygiene and developed in collaboration with WHO and NACO and during 1996 it was continued by ODA. NORAD has also contributed approximately US $ 500,000 in support of the national physician's training programme, conducted by the Christian Medical Association of India in collaboration with NACO and WHO.

- The Overseas Development Administration (ODA) – ODA has begun funding for a 1.5 million Pounds

(Sterling) "Sexual Health Project" in the state of West Bengal over a three years period. This projec focuses on IEC and STD prevention and control strategies in a number of well-defined areas of the state. Additionally, ODA is funding a national IEC/STD project, as well as a national truck drivers intervention project.

The European Community (EC) – The EC has earmarked 500,000 ECU in support of HIV/AIDS/ STD prevention activities by NGOs in a number of states. These funds will be channeled through a nodal agency (the Voluntary Health Association of India).

Non-Governmental Organizations

In addition to Governmental, Multilateral and Bilateral channels, crucial and often innovative support for HIV/AIDS/STD activities has been demonstrated by the community of Non-Governmental and Private Voluntary Organizations in India. It has been repeatedly acknowledged by NACO that NGOs and PVOs are necessary and complementary actors on this stage, as it is beyond the realm of either the Union or State Governments to consider tackling this problem alone. It is through the involvement of these groups, many of whom already have well-established bases of operation within geographical or social sectors, that NACO hopes to ensure that everyone will eventually be reached by HIV/AIDS/STD prevention and control efforts. In fact, national guidelines for the identification and involvement of Non-Governmental Organizations in the fight against HIV/AIDS/STD released in mid-1993, are gradually being applied at National and State levels.

Wide-ranging support has been found throughout the NGO and PVO community for the development and integration of HIV/AIDS/STD prevention and control activities into their existing programme activities. Major support has been provided by local offices of international NGOs such as the Ford Foundation, Oxfam and Population Services International. National NGOs, such as the Christian Medical Association of India (CMAI), Indian Medical Association (IMA) and the Voluntary Health Association of India (VHAI) have also proven instrumental in the implementation of certain aspects of HIV/AIDS/STD prevention and control throughout the country. In addition to state governments, NACO directly supported 28 NGOs in 1996. Their activities ranged from training of grass roots level volunteers to community awareness and targeted interventions for those practicing high risk behaviours.

Corporate Sector

In addition, as noted above, numerous corporate sector organizations, such as the Confederation of Indian Industries, FICCI and the Bengal Chamber of Commerce and Industry, have begun to develop programmes in collaboration with NACO for the integration of HIV/AIDS/STD prevention and control activities into ongoing health care, educational and other social sector activities already being carried out under the auspices of the corporate sector. An innovative effort has been begun by the Tata Iron and Steel Corporation (TISCO), Jamshedpur, to integrate HIV/AIDS/STD education and information into their ongoing corporate family welfare programme.

HIV/AIDS SURVEILLANCE

Highlights of 1996

- Review of sentinel surveillance system for HIV infection was initiated.
- Seven states at 18 surveillance sites completed the fourth round of surveillance, while 29 sites in 12 states completed the third round.
- 19,500 doctors trained in diagnosis of AIDS cases to improve reporting of AIDS cases.

A needs-based surveillance system which provides essential information on the dynamics of the HIV epidemic is necessary not only to monitor trends, but also to provide inputs to further strengthen the programme's control activities and to evaluate the implementation of the AIDS programme in the long run. In this context, the national HIV/AIDS surveillance system has undergone modifications in response to changing needs and scenarios. Introduction of a sentinel surveillance programme is one major development which took place in 1993-94 and has developed further in 1994-95. In addition, for AIDS case surveillance, an intensive training programme for physicians was initiated and is still going on.

Objectives of HIV Surveillance

With the progression of spread of HIV infection, objectives of HIV surveillance have changed to suit the needs arising from new developments in the country. Until 1994, surveillance was based on data generated from 62 surveillance centres situated in different parts of the country. Earlier the data generated from different target groups was pooled and was cumulative in nature and hence did not suit the objective of monitoring trends of HIV infection in the country. The main objective of the current surveillance system is to be able to monitor trends in specific high risk groups and also to monitor trends in groups considered to be low risk, such as antenatal clinic attenders.

HIV Surveillance

Sero-surveillance

India is one of the few countries in the world to have initiated surveillance activities even before any HIV positive cases were detected here. In 1985, the Indian Council of Medical Research (ICMR) started screening blood from some high risk behaviour groups to determine if HIV was present in India. Soon after, in 1986, CMC, Vellore detected an HIV sero-positive sample taken from a commercial sex worker in Chennai.

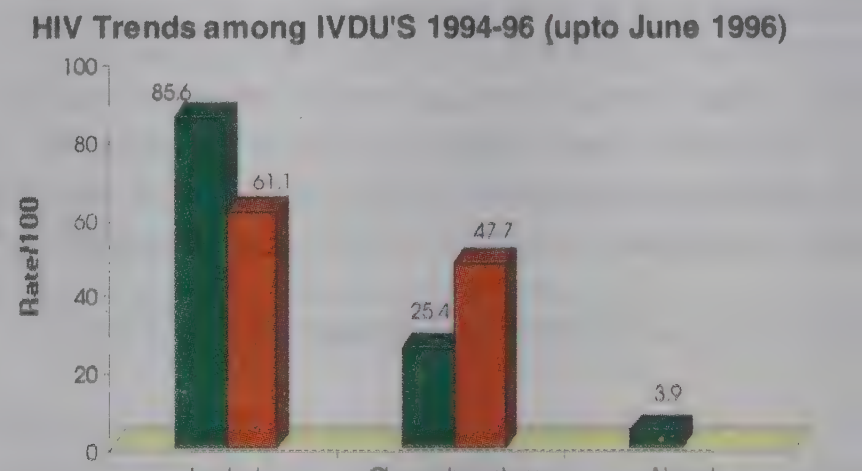
HIV surveillance entered its second phase in May 1986 when its objective was redefined as identifying the geographical spread of HIV infection and determining the major modes of HIV transmission. HIV testing facilities were made available in many parts of the country through the establishment of 62 surveillance centres and 9 referral centres enabling HIV screening in a wider geographical area. The

results of this screening in phase two indicated that HIV infections had reached almost all parts of the country and that heterosexual transmission was the major mode of HIV transmission in India.

Sentinel Surveillance for HIV Infection

A sentinel surveillance system has been adopted since 1993-94, which follows a pre-defined scientific protocol. This includes strict sampling procedures in limited sites with specific population groups. The components essential to the success of the sentinel surveillance programme are outlined below:

Population groups and sites are chosen based on existing information on HIV prevalence among various groups, existence of high risk behaviours and socio-economic factors. At most sites, the following identified groups are included:



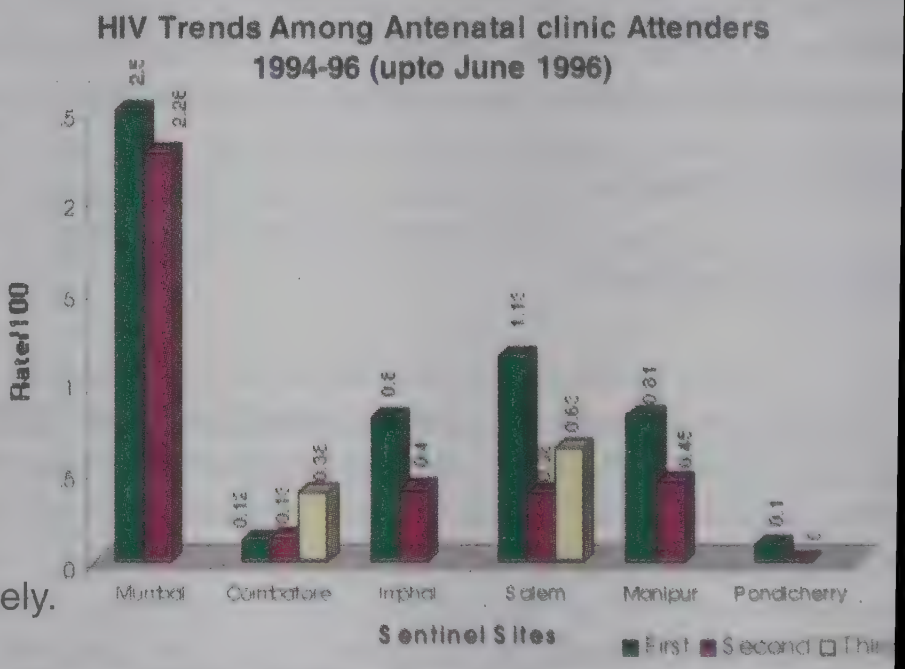
High risk groups:

- STD clinic attenders,
- Injecting drug users

(These two groups are usually more vulnerable to HIV infection and, therefore, more useful for monitoring the epidemic in its early stages.)

Low risk groups

- Pregnant women from antenatal clinics as representatives of general population.



The trends of HIV infection will be monitored among these groups over time with one round of sentinel surveillance every year.

A sample size of 400 for STD clinic attenders and IVDUs and 800 for pregnant women has been set up which will provide results with sufficient accuracy at the present HIV prevalence levels. The sampling period is 6 to 8 weeks, which decreases the chance of repeat testing of the same people and will determine the trends more accurately.

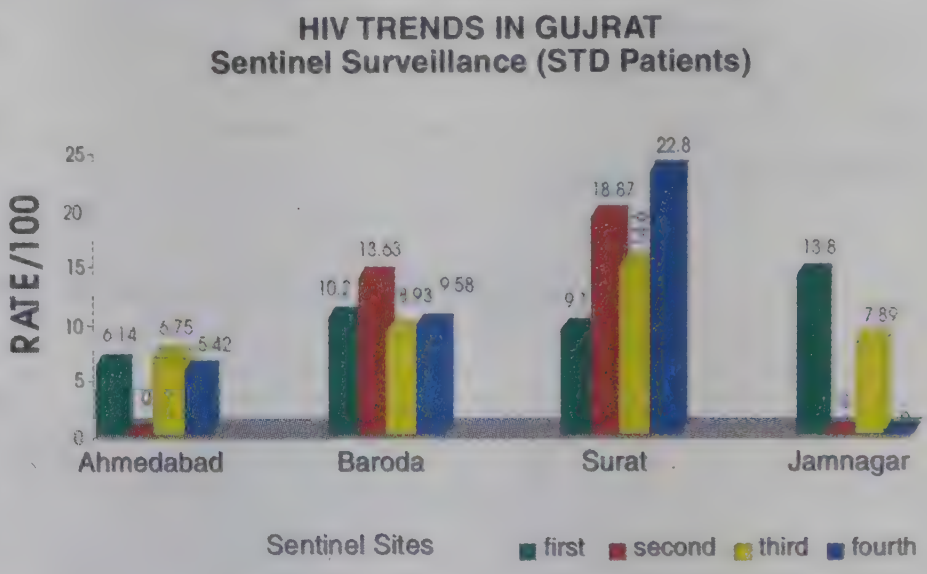
For surveillance purposes, *serial testing with two ERS (ELISA, Rapid, Simple) tests* has been recommended without reference to Western Blot.

In order to implement this programme, *a training module on HIV sentinel surveillance* was prepared

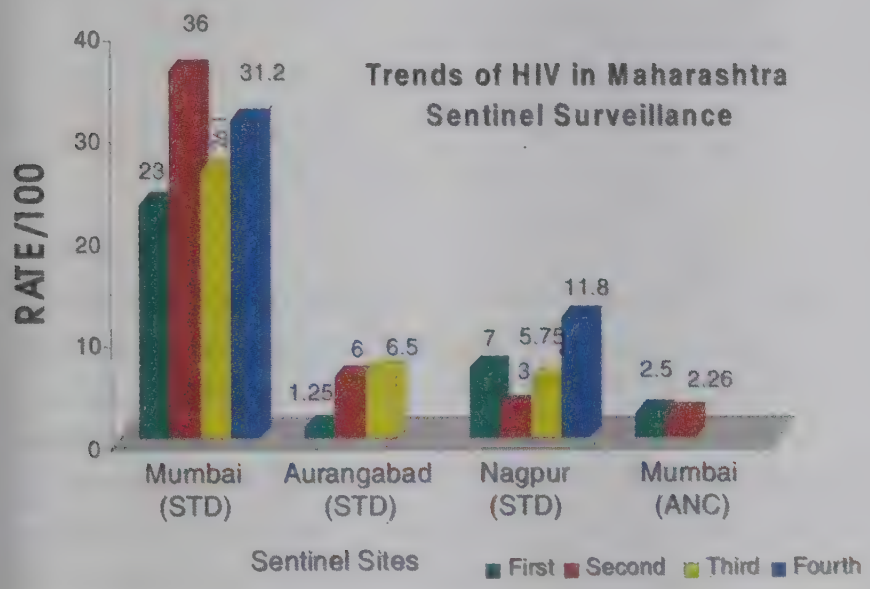
and a training programme implemented for all state epidemiologists and state AIDS programme officers (SAPO) in March-April 1993. As a result of this training, the following developments have taken place:

- 26 States have prepared sentinel surveillance protocols which have been approved and funded;
- 55 sentinel surveillance sites have been selected;

From 1986 to 1989, HIV surveillance results were reported to the Ministry of Health and Family Welfare using formats designed by the ICMR to meet the surveillance objectives of the late 1980s. In 1993-94, HIV sentinel surveillance, the methodology was modified according to the new NACO guidelines, and new report formats have been in use ever since.

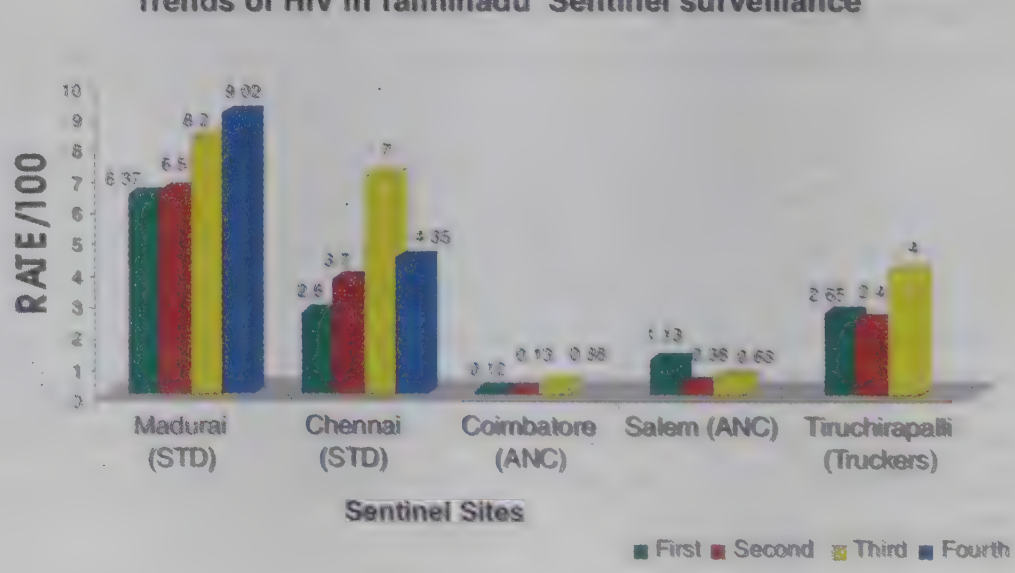


The *development of a sentinel surveillance system* for tracking the progression of the HIV epidemic in India has yielded useful results. These include reliable information on dates and trends of infection. This helps government and non-government programme managers at state and local levels to plan effective programmes and service delivery. This information is also extremely important in the advocacy process with key local, state and national policy and decision makers.



The first round of sentinel surveillance has been conducted and analyzed at 55 sites in 22 states; the second round in 32 sites in 14 states; the third round in 29 sites in 12 states and fourth round in 18 sites in 7 states, as of Dec. 1996.

The results of these rounds as shown in tables below indicates a very high prevalence of HIV infections among STD clinic attenders and IVDUs and is indicative of the fact that the HIV infection



has started percolating down to general populations, as is evident from data analyzed from sentinel sites in antenatal mothers' clinics.

The present sentinel surveillance system has less representative populations groups as well as no representation of rural populations. Accordingly, this system is being expanded and strengthened in order to get adequate and reliable data to monitor the trends of HIV infection. In view of the above, every State/UT in the country has been asked to have 3-5 sentinel sites with high and low risk groups being represented in a ratio of 2:1.

SENTINEL SURVEILLANCE SYSTEM FOR HIV INFECTION

Rounds	Sites	States
I	55	22
II	32	14
III	29	12
IV	18	7

AIDS Case Surveillance

Subsequent to the detection of the first AIDS case in 1986, efforts were made under the NACP to diagnose the clinically suspected cases of AIDS. Initially, four groups of medical personnel consisting of one doctor and one nurse from Delhi, Chennai, Mumbai and W. Bengal were sent to Australia for a 6 weeks course on clinical management and diagnosis of AIDS. After this a crash training programme was held for 2200 key trainers with the objective of improving the skills of medical personnel for diagnosing suspected cases of AIDS. At the same time, the Government of India recognized 14 institutions all over the country as key training institutions for conducting this training. A massive training programme for diagnosis of AIDS cases led to training of about 19500 doctors, including general practitioners and private practitioners. These training courses were conducted in collaboration with the Indian Medical Association and the Christian Medical Association of India.

Under this programme, state physicians responsible for AIDS management (State PRAM) have been identified in each state/UT to effectively diagnose and manage the AIDS cases. They were also entrusted with the responsibility of submitting this information on AIDS case surveillance to State AIDS Cells and the NACO. Majority of the states reported AIDS cases on a regular basis and as on December 1996, 3161 cases were reported to NACO. But this does not represent the true picture because of under reporting of AIDS cases. A need is felt to develop a mechanism to ensure that all AIDS cases which are diagnosed are reported to NACO. AIDS cases reporting system could also supplement the HIV sentinel surveillance data in monitoring the epidemic and could contribute to the planning of hospital and home community care for AIDS patients.

AIDS CASES IN INDIA (REPORTED TO NACO)
(AS ON 31st DECEMBER, 1996)

S.No.	STATE/UNION TERRITORY	AIDS CASES
1.	Andhra Pradesh	24
2.	Assam	10
3.	Arunachal Pradesh	0
4.	Andaman & Nicobar Islands	0
5.	Bihar	2
6.	Chandigarh (U.T)}	
7.	Punjab }	100
8.	Delhi	116
9.	Daman & Diu (U.T)	1
10.	Dadra & Nagar Haveli (U.T)	0
11.	Goa	12
12.	Gujarat	128
13.	Haryana	1
14.	Himachal Pradesh	9
15.	Jammu & Kashmir	2
16.	Karnataka	63
17.	Kerala	102
18.	Lakshadweep (U.T)	0
19.	Madhya Pradesh	66
20.	Maharashtra	1561
21.	Manipur	154
22.	Mizoram	0
23.	Meghalaya	0
24.	Nagaland	4
25.	Orissa	2
26.	Pondicherry (U.T)	124
27.	Rajasthan	3
28.	Sikkim	0
29.	Tamil Nadu	571
30.	Tripura	0
31.	Uttar Pradesh	56
32.	West Bengal	50
	Total	**3161**

STATEWISE
SERO-SURVEILLANCE FOR HIV INFECTION
Period of report up to: 31st December, 1996 (Provisional)

S.No.	STATE/UNION TERRITORY	SCREENED	POSITIVE
1.	Andhra Pradesh	43164	290
2.	Assam	10780	150
3.	Arunachal Pradesh	366	0
4.	Andaman & Nicobar Islands	9741	85
5.	Bihar	8403	17
6.	*Chandigarh (U.T)	55104	184
7.	Punjab	56	4
8.	Delhi	314213	1244
9.	Daman & Diu (U.T)	250	8
10.	Dadra & Nagar Haveli (U.T)	Report not received	1
11.	Goa	60125	1040
12.	Gujarat	369960	527
13.	Haryana	132381	219
14.	Himachal Pradesh	13767	71
15.	Jammu & Kashmir	8955	34
16.	Karnataka	367685	2630
17.	Kerala	43927	215
18.	Lakshadweep (U.T)	753	7
19.	Madhya Pradesh	83536	345
20.	Maharashtra	336996	32014
21.	Manipur	40557	3712
22.	Mizoram	23147	72
23.	Meghalaya	14013	57
24.	Nagaland	3344	261
25.	Orissa	79633	205
26.	Pondicherry (U.T)	71229	2069
27.	Rajasthan	33374	125
28.	Sikkim	171	1
29.	Tamil Nadu	575954	2986
30.	Tripura	20871	13
31.	Uttar Pradesh	112385	689
32.	West Bengal	102505	252
	Total	**2937345**	**49527**

*Includes people coming from Punjab

SEXUALLY TRANSMITTED DISEASES

Highlights of 1996

- 18,558 medical officers from various states trained in STD case management through syndromic approach.
- 132 new STD clinics along with the existing 372 upgraded to become referral centers of primary health care facilities.
- 5 regional STD referral centres upgraded to conduct training, research, supervision and monitoring.
- More than 10,000 private health care providers trained in STD case management by IMA in collaboration with NACO.
- Two documents on Syndromic Management of STDs and Treatment Guidelines revised and updated.
- Training module on STD surveillance prepared and finalized for training state AIDS/STD program officers.

Introduction

Both STD and HIV infection/AIDS are associated with the same risk behaviour, that is, sexual intercourse with multiple partners. There is growing evidence that the presence of an STD greatly facilitates both the acquisition and transmission of HIV infection. India has a high incidence of STDs with an estimated annual incidence rate of 5% or 40 million new cases a year. In Mumbai, over a short period of time HIV prevalence reached 50% in sex workers and 36% in STD patients. An estimated 3-4% of some rural populations have an STD. There is good evidence that concomitant infection with other STDs, particularly those characterized by genital ulcers, facilitates HIV infection. For example, it has been estimated that the risk of a woman acquiring HIV from sexual intercourse doubles (at least) if she has an STD.

In a study in the Mwanza region of Tanzania, a near 40% reduction in new HIV infections was achieved through the implementation of a comprehensive public health STD prevention and care programme. Early diagnosis and treatment of STD has, therefore, the potential to reduce the transmission of HIV. Primary preventive measures for the prevention of STD will also prevent sexual transmission of HIV infection. Such measures include IEC to promote safer sexual behaviour, including condom use and provision of good quality condoms.

Relationship between HIV/AIDS and other STDs, as summarized below, establishes why the control and prevention of STDs is now recognized as one of the major strategies to control the spread of HIV infection and AIDS.

Relationship between HIV infection and other STDs

- The predominant mode of transmission of both HIV infection and other STDs is sexual, although other routes of transmission for both include blood, blood products, donated organs or tissue and through an infected woman to her foetus or newborn infant.
- Many of the measures for preventing the sexual transmission of HIV and STDs are the same as are the target audiences for these interventions.
- STD clinical services are an important access point for persons at high risk for both HIV and STD not only for diagnosis and treatment but also for eduction on prevention.
- There is strong association between the occurrence of HIV infectionand the presence of other STDs. Increasing evidence suggests that many STDs significantly enhance the acquisition and transmission of HIV.
- Increasing evidence suggests there is increased severity of manifestations and infectivity of STD and reduced response to conventional therapeutic regimens in HIV infected persons.
- Trends in STD incidence and prevalence can be useful indicatiors of changes in sexual behaviour and are easier to monitor than trends in HIV sero - prevalene and are, therefore, valuable for determining the impact of HIV/AIDS control programmes.

Many people fail to seek help or suffer from reinfection or persisting infection. This has important implications for any attempts to prevent the spread of HIV.

Some Facts Regarding STDs

- STDs are very common in urban and many rural areas in the country.
- Many STD patients rely on informal or traditional sources of health care for STD, or resort to self-medication.
- Most STDs are curable, if early and effective medical care is obtained.

Current Provision of STD Services in India

A centrally sponsored National STD Control Programme has been in operation in India since 1946. This became a part and parcel of the National AIDS Control Programm in 1992. It is based on a limited number of specialized STD facilities offering clinical services fo diagnosis and treatment of STD, and relies on the health care seeking behaviour of individuals wit STD. The facilities currently providing STD services are: five regional STD reference centres (Delh Chennai, Hyderabad, Nagpur and Calcutta); the skin-leprosy-STD clinics in Medical Colleges and i some district or Taluka hospitals; and municipal STD clinics in some cities.

It is estimated that only a very small percentage (5-10%) of all people with STD attend thes public STD facilities. The majority seek clinical care either from the formal or the informal privat sector or resort to self-medication.

The only health facilities which offer easily accessible and acceptable services to women an

are perceived as non-stigmatizing are the family welfare services, such as MCH, FP and ANC clinics. These are integrated in the first level health care services at PHC and Community Health Centre level, covering almost all rural populations and most urban populations. The mandate of these services is reproductive health in broad terms, which includes sexually transmitted infections.

Objectives

The objectives of the STD control component of the National AIDS Control and Prevention Programme are:

- to reduce the transmission of STD and hence of HIV infection by reducing the risk factor effect for HIV transmission associated with the major STDs;
- to prevent the development of short- and long-term morbidity and mortality due to STD.

Gender Perspective

- *Many sexually transmitted infections in women are asymptomatic or poorly symptomatic (for instance, > 50% of Gonorrhoea in women is asymptomatic); thus there is no incentive to seek health care.*
- *Most women have very limited understanding and awareness of sexual and reproductive health; thus even in the presence of symptoms, these are frequently ignored or not associated with STD.*
- *The taboos surrounding sexuality and STD lead to a situation where people, in particular women, seeking health care for STDs are stigmatized; this is especially the case where STD care is provided through easily identified, specialist STD clinics.*
- *Women feel uncomfortable being examined by male doctors, but very few female doctors are employed in STD clinics; thus even if women attend STD clinics, they are usually not examined and treatment is often inadequate.*

Policy and Strategy Development

The Ministry of Health and Family Welfare has adopted a policy to integrate STD control into the existing health care system, both public and private. Special emphasis is being placed on the integration of comprehensive STD case management at the primary health care level to provide non-stigmatized services with greater accessibility and acceptability to the patients while maintaining confidentiality and privacy of the patient.

Cooperation from and collaboration with the private sector and NGOs will be promoted and actively sought.

The Ministry of Health and Family Welfare's STD policy document was widely distributed. A fourth meeting of the technical advisory subcommittee on STD took place, during which a number of manuals and guidelines were discussed and approved.

In recognition of this the Ministry of Health and Family Welfare has undertaken steps to incorporate activities for prevention of STD and HIV infection, and for control of STD in the ongoing family welfare services. A number of pilot projects are currently being developed to assess the required inputs, the feasibility and the cost-effectiveness of this approach. The Department of Family Welfare

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has conducted pilot projects in two states, Orissa and Karnataka.

The following main strategies, as outlined in the Strategic Plan for the Prevention and Contro of AIDS in India, are being developed and employed:

1. Adequate and effective programme management
2. Prevention of the transmission of STD/HIV infection, through IEC, promoting safer sexual behaviou including the consistent use of condom.
3. Adequate and comprehensive case management including diagnosis, treatment, individua counselling, partner notification and screening for other diseases.
4. Increasing access to adequate health care for STD, by strengthening existing facilities and healt care structures, and the development of new facilities where necessary.
5. Early diagnosis and treatment of mostly asymptomatic infections through case-finding and screening

Action has been taken on these strategies and activities along the lines mentioned below hav already been started:

1. Training of health care workers, in both public and private sectors, in comprehensive STD cas management.
2. Development of appropriate laboratory services for the diagnosis of STD.
3. Microbiological and socio-behavioural research, and operational research:
4. Surveillance, to follow the epidemiological situation and to monitor and evaluate the implementatio of STD control programmes and their effectiveness.

Programme Management

- A Consultant (STD) is employed by NACO to assist the Additional Project Director (Tech) in a activities relating to STD control.

- A number of state AIDS Programme Officers have appointed STD Programme Officers in the stat AIDS cell. NACO continues to support the development, implementation and monitoring of stat STD control activities.

Prevention of Sexual Transmission of STD/HIV Infection Through IEC

- IEC activities for the primary prevention of STD and HIV infection are developed and implemente through the IEC component of the National AIDS Control Programme. An important IEC activity related to improving the awareness of STD, and the promotion of appropriate health care seekin behaviour.

- A generic set of educational material on STD for people with low literacy for use in health ca facilities has been developed. The material provides basic information on STD, on their symptom

and on the need for adequate treatment. Attention has also been paid to issues of treatment compliance, partner notification and prevention of future infections.

Shenbagam

Shenbagam is a mother of two. She and her family live in a crowded tenement in one of Palani's numerous slums. Her husband, Muthu, works as an autorickshaw driver.

After suffering frequently from genital irritation and discharge, she learnt from one of the society's (an NGO working in Oddanchatram, Tamil Nadu) animators that what she had was called an STD. She also learnt about HIV and AIDS, and knows that she is extremely vulnerable to infection because of her husband's sexual behaviour.

Shenbagam feels that she must have got the STD from her husband, who spends a lot of money on sex with different women every month. She also knows that he makes extra money booking clients for sex workers, but is unable to argue about these matters.

Fearing that Muthu would suspect her of having an affair with someone else, Shenbagam did not dare tell him that she was suffering from an STD. However, she decided to get treatment, without his knowledge, at the society's clinic, where the nurse also gave her condoms.

When Shenbagam first showed Muthu a condom and told him it could protect them both from AIDS, he beat her up. Shenbagam told an animator from the Society about the problem. The animator then arranged a slide show on AIDS for the men in the neighbourhood and persuaded Muthu to attend it.

The slide show was followed by a discussion, which made Muthu examine his own sexual behaviour. He now discusses AIDS with his friends, and has begun to use condoms whenever he visits sex workers. "It took a while to convince him," says Shenbagam, "but things have changed for the better."

(Case Study courtesy 'Broadening the Front' by Jaya Shreedhar and Anthony Colaco)

STD Case Management

- Two publications were widely distributed: "Simplified STD Treatment Guidelines" for use in all first level health care facilities; and "STD Treatment Recommendations" for reference by STD specialists.

- First level health care facilities are being strengthened to ensure the provision of good quality and effective STD case management at the point of first contact. An important component of this is training of health care workers in the PHC system. Training on STD and HIV infection/AIDS has already been given to ANMs, MPWs and aanganwadi workers in some states. Similar training is also being extended to other states.

- As laboratory facilities are extremely limited in the primary care setting, the adoption of the

syndromic approach in the management of STD cases seems favourable in terms of cost effectiveness.

- The syndromic approach involves treating patients on the basis of their symptoms. As several STDs may present with the same clinical picture, this may result in treating with more than one antibiotic. However, this has not been associated with increased drug resistance or partially treated infections, and would appear to be a favourable approach for primary care settings with limited facilities. Studies for further evaluation are being conducted at three different places.

Secondary and Tertiary (Specialist) Facilities

- The 504 existing STD clinics in Medical Colleges, and in District and Taluka Hospitals have been strengthened so far, 132 in 1996 alone, through the provision of laboratory equipment and training of manpower. These clinics will play a role in training of medical and paramedical personnel, and will act as referral centres for first level health care services in their catchment area.

- The five Regional STD Referral Centres have been upgraded and laboratory facilities provided to enable these centres to play a role as reference centres for training, research, supervision and monitoring, and as STD referral centres for first level health care services.

- Indian Medical Association (IMA), in close collaboration with NACO, has given orientation and training courses to more than 10,000 private health-care providers in STD case management

Increasing Access

- To the extent possible use is being made of existing health facilities for the provision of STD case management. It is not foreseen to expand the number of specialized STD clinics, but rather to offer STD services through their integration into first level health care. To this end operational and health systems research regarding the integration of STD clinical services in MCH/FP and antenatal clinics is continuing.

- A study on health care seeking behaviour in relation to STD is being conducted at three different places which will assist in formulating strategies to render existing facilities more acceptable and accessible to people with STD. This study might also indicate other formal or informal health care providers, with whom collaboration might be sought to improve STD case management.

- Two pilot projects are currently under development to assess the relative merits of an approach providing STD care through mobile teams.

Case-finding and Screening

- In the absence of simple diagnostic tests for STD, the feasibility of case-finding and screening ar

limited. A review of the status of maternal and congenital syphilis control in India is planned. If required, a plan will be developed to strengthen and implement universal screening for syphilis, and subsequent treatment, for all antenatal clinic attenders.

Activities and Plans

1. Training Material

An interactive training module, consisting of six volumes, for the training of trainers from medical colleges, who in turn will train medical officers and PHC level health care workers in STD case management has been published. This module is based on a number of case studies and utilizes the syndromic approach to case management, allowing first level health care workers with no or limited access to laboratory support to adequately manage 90-95% of all STD patients.

- A reference manual for laboratory workers "Laboratory Diagnosis of Sexually Transmitted Diseases" has been widely distributed. This manual is intended for laboratory technicians working in STD laboratories, but can also be used by laboratory technicians working at the PHC level.
- A module on health education and counselling for STD patients will be developed by the IEC team.
- A protocol and training module on STD surveillance is under development.
- Training materials - 'Simplified STD Treatment Guidelines' and 'STD Treatment Recommendations' - prepared earlier are being revised and updated and will soon be ready for publication.

2. Training Activities

In the year 1996-97 regular STD training activities were conducted by the state governments through their respective state AIDS cells for medical officers in service and for private practitioners.

The state of Maharashtra has trained 4651 medical officers, Tamil Nadu - 3700, W. Bengal - 2348, Pondicherry - 110, Haryana - 82, Delhi - 250, Assam - 2417 and Uttar Pradesh - 5000.

The defence services have also trained their medical officers in STD case management through syndromic approach. .Para-military forces like, CRPF, and the Indian Railways have also taken initiative in training of their medical officers in STD through syndromic approach

Two training workshops for the junior microbiologists and medical officers in-charge of the laboratory were held in which 60 participants were trained. Six training workshops were held for laboratory technicians, at various places in the country by the NICD, New Delhi, to train them in the diagnosis of STDs. The state of Tamil Nadu has trained 559 laboratory technicians, W. Bengal - 710, Pondicherry - 24 and Assam - 70.

3. Laboratory Services

Laboratory services in the five regional STD referral centres, and the STD clinics in medical

colleges and District and Taluka hospitals are being upgraded.

However, it is recognized that the management of STD patients will be predominantly on clinica basis, and that laboratory support will mainly be reserved for:

1. diagnosis of difficult cases;
2. management of treatment failures;
3. research and antibiotic susceptibility monitoring.

A proposal for strengthening the quality assurance system for STD laboratories will be developed This will initially involve upgrading the existing syphilis serology quality control system, and establishin a quality assurance mechanism for the diagnosis of gonorrhoea.

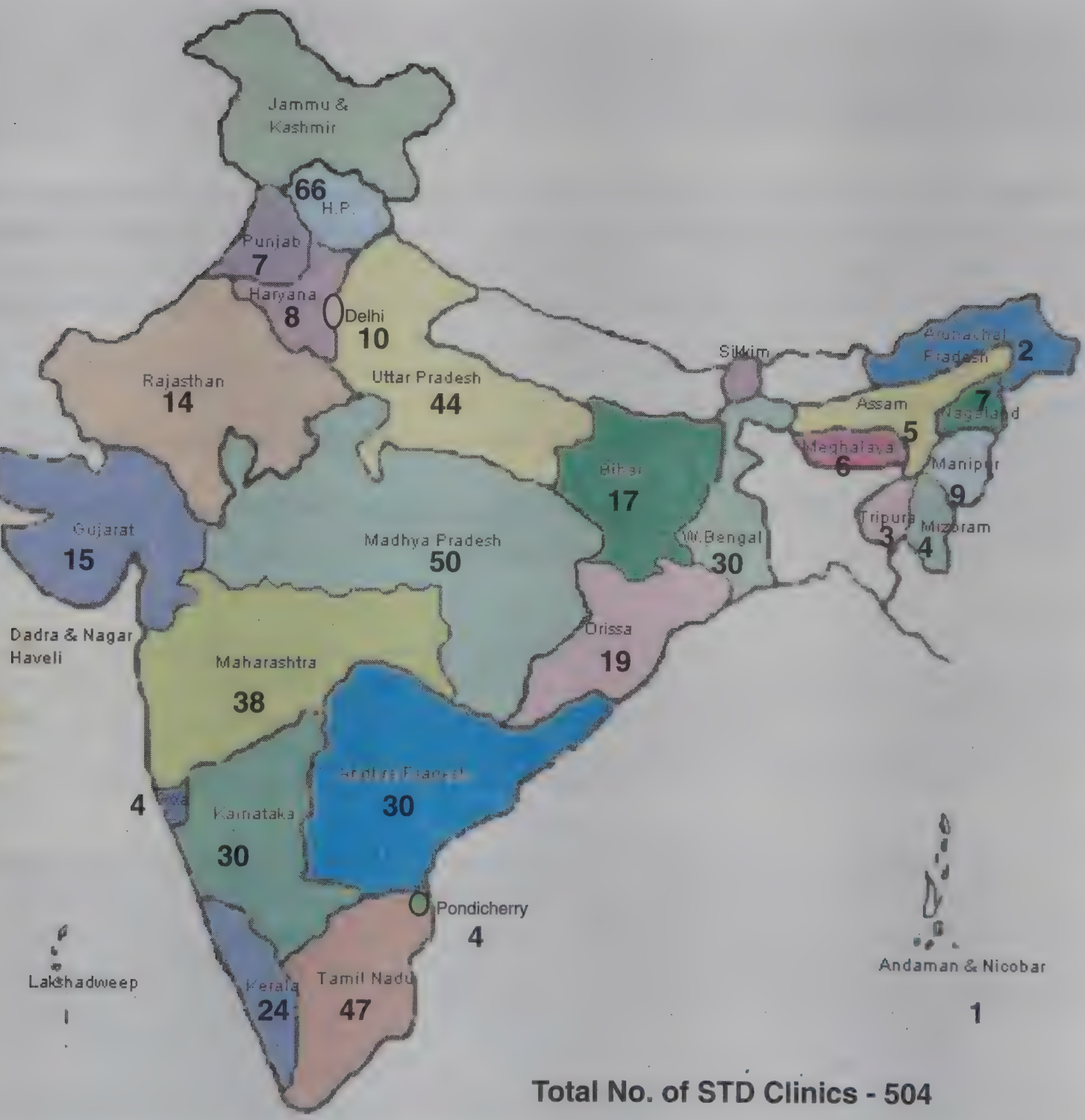
4. Research

- A number of baseline studies on STD prevalence have been carried out in Tamil Nadu, Calcutt and Jaipur. There findings have been reported in earlier updates. Further STD baseline studies ar planned in Andhra Pradesh, Himachal Pradesh and Assam to further document the prevalence o STD in different parts of the country.
- A study of the prevalence of STD in pregnant and non-pregnant family planning/maternal and chil health clinic attenders has been completed in East Delhi and the final report is awaited. Preliminar results, however, show high rates of C. trachomatis infection in both groups.
- Operational health and systems research will be conducted, to assess the feasibility of integratin STD clinical services in MCH/FP and antenatal clinics in urban and rural areas.
- Studies to validate the flow charts used in the syndromic approach are being conducted.
- Work has started on the development of an antibiotic susceptibility monitoring network for gonorrhoea

5. Surveillance

A draft STD surveillance protocol based on sentinel site reporting and occasional surveys wa developed during a consultation in Delhi in 1994. In this connection it is now planned to prepare training module in a workshop early next year, which will be used for training of state AIDS/STD progra officers.

STD CLINICS IN INDIA



CONDOM PROGRAMMING

Highlights of 1996

- Over 50 per cent increase in the volume of condom distribution through social marketing.
- Quality of the cAondoms improved to meet WHO specifications.
- A market research on condom usage enters its second and final phase.
- Condom distribution greatly promoted by intervention projects run by various NGOs, supported by NACO.

Almost 75% of HIV transmission is through unprotected, multi-partner sexual intercourse which in theory, is almost totally preventable by consistent use of good quality condoms. However, 100% prevention, though not possible in reality, is a target worth chasing. This is the single most easily affordable and potent answer to the problem of HIV transmission. The major issues in condom programming are

- To sensitize people to the use of condom as a preventive measure against HIV/AIDS/STD and not merely as a family planning device.
- To convince people that condom use is as important as a life saving drug for those visiting commercial sex workers.
- To make low-cost, good quality condoms available to people easily at the time and place they need it most.

Background

The condom market in India is currently relatively small, catering mostly to contraceptive needs of users, and covers only 5% of the eligible couples. The condom market primarily belongs to the

DISTRIBUTION OF CONDOMS THROUGH VARIOUS CHANNELS
(Million Pieces)

SCHEME	1993-94	1994-95	1995-96	1996-97*
FREE	914.00	916.52	875.00	720.29
SOCIAL MKT	218.24	146.10	162.92	262.42
COM. SALES	155.52	154.92	199.33	239.25
TOTAL	1287.76	1217.54	1237.25	1222.06

*Up to Feb. 1997

Government owned brand name "Nirodh". The government's policy is to reduce the volume of free distribution and vigorously pursue social marketing of condoms while encouraging commercial sales of the same. An encouraging increase of over 50% has been recorded in the volume of condoms distributed through social marketing in the year 1996.

Objectives and Strategies

The objective of the condom programming component is to ensure easy access to good quality, affordable and acceptable condoms.

The following main strategies are outlined in the Strategic Plan for the Prevention and Control of AIDS in India:

- to provide technical assistance to companies to manufacture condoms in conformity with the international specifications laid down by the WHO and improve the quality assurance system;
- to strengthen the existing social marketing structures in the Department of Family Welfare with a view to fulfilling the needs and requirements of the AIDS Control Programme;
- to strengthen the management ability of PVO/NGOs that promote and distribute condoms for STD/ HIV prevention to more effectively plan, coordinate, monitor and evaluate their activities;
- to collaborate with the existing IEC programme of the Department of Family Welfare for promoting the use of condoms for achieving the dual purpose of averting birth as well as protection from AIDS/ STDs;
- to strengthen programme management and monitoring systems;
- to support and strengthen the ICMR and Population Research Centres for undertaking research studies on all matters related to the use of condoms and increasing its use, particularly among high risk groups.

Quality Control

Condom specifications have been brought within the quality parameters as described by WHO through revision of Schedule "R" of the Drugs and Cosmetics Act. All the manufacturers are meeting the new specifications for all orders by the Department of Family Welfare. The unlubricated Nirodh condom has already been phased out.

All the states have been provided with the latest testing equipment to ensure the quality of condoms at the time of procurement. Random samples of condoms are drawn from the field also and tested for retention of quality within the stipulated 3 years of shelf life. Support has been given to

Hindustan Latex Ltd, the largest condom manufacturer in the country, to strengthen its quality control system. In addition to this, support is available for the development of an independent quality control laboratory.

Social Marketing of Condoms

Social marketing of condoms is an important strategy to increase the acceptability of and access to condoms, while improving the sustainability of condom provision. This has been well demonstrated by the reports of the Bhoruka AIDS Project (BAP), Raxaul'.

The free distribution of condoms, although important as a means of introducing first time users to the product, is not recommended on a large scale. Reasons for this are the lack of sustainability of such a large programme, as well as doubts about the actual utilization rate of freely distributed condoms. Preference is, therefore, give to social marketing of condoms, where the user pays a (subsidized) price for the product.

Condom Distribution Report (BAP Raxaul)

Aug	6,500	Dec	3,870	Apr	2,560
Sep	5,570	Jan	6,630	May	939
Oct	7,900	Feb	5,970	Jun	1,452
Nov	4,685	Mar	11,880	July	1548

- A total of 8 condom distribution points have been created at tea shops, paan shops and dhabas.
- An average of 10 condoms has been distributed free of cost to every clinic attender in July 1995-96
- A downtrend observed in April was due to erratic supply of condoms.
- In addition to the clinic, 3 condom selling points had been created near the parking zones.

Activities and Plans

- It is recognized that the target group for condoms for disease protection is not identical to the grou using condoms for family planning purposes. Market research is required to better segment an describe the various potential user groups, and to better target marketing and IEC strategies. market research contract has been awarded to Mode after the ICMR had reviewed their proposa The research is in its second and final phase.

- Following market research, appropriate strategies for condom social marketing will be developed. is envisioned that a possibly heterogeneous market is best served by a large number of smalle NGOs implementing social marketing strategies, possibly under the aegis of an umbrella organizatio

- To make the condoms easily available at all times and to the people who need it the most, like thos who routinely visit sex workers, vending machine pilot project is ongoing in Bombay and Pune. Thi project started in 1993, and so far a prototype machine has been approved, and 15 sites identifie The delivery of machines is awaited.

Strengthening of Private Voluntary Organizations & Non-Governmental Organizations

Workshops to increase the involvement of PVOs and NGOs will be organized in future. The aims

these workshops are:

- to disseminate the results of market research;
- to motivate PVO/NGOs to play a more important role in social marketing of condoms;
- to strengthen the management capability of these PVO/NGOs in terms of condom programming.

The Deptt. of Family Welfare has agreed to meet all condom needs of the STD/AIDS control programme, by supplying clinics and treatment facilities, as well as NGOs working in STD and HIV prevention. The Deptt. of Family Welfare has also agreed to position condoms as a dual protection device, protecting against both pregnancy and STD, and HIV infection.

Strengthening programme management and monitoring systems workshops on logistics management will be planned at a later stage, and a management information system has been developed.

Kanniram

Kanniram is a married man of 30 with two children. For the past 15 years, he has been running a *dhaaba* off National highway no. 8 in Rajasthan. He first heard about AIDS from Seva Mandir's (an NGO working in Udaipur) health workers. Today, his *dhaaba* displays posters and stickers on AIDS and hands out pamphlets to customers.

With thousands of trucks from different parts of the country passing by, the *dhaaba* does brisk business. The AIDS posters and the condom dispenser invariably spark off a discussion on AIDS amongst the truckers. Kanniram and his workers explain how condoms can give protection against AIDS and more immediate problems like STDs. There is now a great deal of awareness among the truckers, and most do not leave the *dhaaba* without stocking up on condoms from the dispenser installed and supplied by Seva Mandir.

Nearly 50 women in the area sell sex, serving both the truckers as well as a considerable number of men from Kanniram's own village. STDs are widespread, but the village men have begun stopping at the *dhaaba* to pick up condoms before visiting the sex workers.

However, the problem of STDs remain as sometimes the condoms tear during sex. When this happens, the men wash themselves with water and urine in the mistaken belief that this will cure them of any STDs they might have contracted. They are not sure whether the practice will also protect them from AIDS.

(Case Study courtesy 'Broadening the Front' by Jaya Shreedhar and Anthony Colaco)

BLOOD SAFETY PROGRAMME

Highlights of 1996

- 207 additional blood banks modernized.
- Supreme Court judgement on revamping of blood banks delivered in January.
- National Blood Transfusion Council set up in May.
- State Blood Transfusion Councils set up in all states/UTs.
- National guidelines for the appropriate use of blood developed and circulated.
- Income Tax Act revised to provide 100% deduction from gross total income in respect of donations made to the Blood Transfusion Councils.

Introduction

Blood is a good medium for growth of any organism because of its nutrient value, adequate oxygen content and adequate temperature. Transfusion of infected blood, therefore, can lead to transmission of Blood Transmissible Diseases, namely, hepatitis, syphilis, malaria and HIV/AIDS. HIV is the latest addition to the list of blood transmissible diseases. The Blood Safety Programme was initiated in the year 1989-90 and subsequently became an integral part of the National AIDS Control Programme. Earlier, testing of blood for blood transmissible diseases was mandatory. HIV testing also has been made mandatory as transfusion of HIV infected blood is the most efficient (> 90%) means of transmitting HIV infection.

The Challenge

In India, blood collection, storage and issue takes place mainly in blood banks attached to hospitals, most of which are under central and state governments. A significant portion of the blood banking activity is also carried out by voluntary agencies and private sector blood banks. The base line data of the existing blood banking services was provided by a study conducted by A. F. Ferguson & Co which identified major shortcomings in the blood banking system viz. the Blood transfusion Services infrastructure is highly decentralized and lacks many critical resources, mainly trained people, equipment supplies and financial support. There is overall shortage of blood, particularly that contributed by voluntary donors.

In the absence of a National Programme, the critical issue which plagues our Blood Banking System is its fragmented management. The centres operate in total isolation and their standards vary from State to State; city to city and centre to centre in the same city. In spite of hospital-based system many large hospitals and nursing homes do not have their own blood banks and this has led to mushrooming of commercial blood banks.

Response

The acute shortage of blood, which is a vital input in today's medicare services, is hampering the effectiveness of our services. To ensure adequate blood banking services at the state/district level, to educate and motivate people about blood donation on a voluntary basis and to enforce quality control of blood necessary action has been taken in right earnest.

The Strategic Plan

Based on the National Policy framework on blood transfusion services, developed by the Central Council of Health and family welfare, eight objectives were developed in the strategic plan for the prevention and control of AIDS in India. They are:

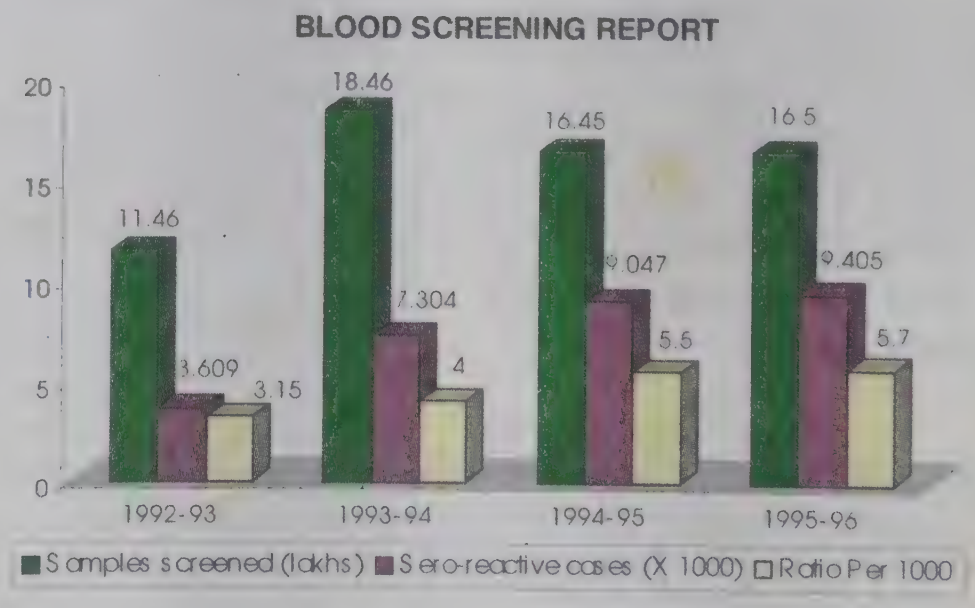
1. Strengthening the National Blood Transfusion services.
2. Ensuring an adequate supply of blood to all blood centres.
3. Ensuring the safety of blood and blood products.
4. Developing facilities for the production of components.
5. Developing and strengthening facilities for plasma fractionation.
6. Strengthening external quality control of blood and blood products.
7. Undertaking research on blood transfusion services, operations to improve safety, efficacy and supply.
8. Developing and strengthening of effective management, monitoring and evaluation of blood transfusion services.

Blood Safety is an integral component of the National AIDS Control Programme. In the respective State AIDS Cells, majority of the states have assigned Blood Transfusion Officers to coordinate the programme at the state level. Assistance is provided by the Government of India for staff, salary, contingency, equipment and vehicles. The staff provided under this component are Joint/Deputy Director, Technical Assistant and Drug Inspectors.

Programme Thrust Areas

Establishment of HIV Testing Facilities

During the past 3 years 154 zonal blood testing centres have been established providing linkages with other blood banks affiliated to the public, voluntary or private sector. The zonal centres receive samples of blood from the blood banks attached to them for testing and provide blood banks with the results of the HIV test the same day. The WHO recommendations of donated blood for



*data pertains to blood banks supported by NACO

HIV testing strategy provides that all samples are to be tested with either ELISA or Rapid/Simple test We have adopted this as a policy. The strategy adopted is to carry out unlinked anonymous tests with kits which test for both HIV I and HIV II and the unit found positive for HIV is discarded by heat treatmen followed by incineration. Based on information on blood screening the status of seropositivity in the donated blood is represented in the preceding chart on blood screening.

Support for testing for other blood transmissible diseases

Besides HIV, it is mandatory to test every unit of blood for hepatitis, syphilis and malaria. National AIDS Control Organization is providing financial support to all the public sector blood banks by giving contingency grant for purchase of test kits, reagents, glassware and blood bags.

The incidence of VDRL, HBSAg and HIV antibodies in the donor is variable in different zones o the country. Approximate data is shown as below:

Transmissible Infections for which blood units tested	DELHI	VELLORE	MUMBAI	CALCUTTA
VDRL	4.5%	0.26%	0.16%	.14%
HBsAg	3.2%	3.0%	2.07%	.2%
HIV I & II	1.35%	0.45%	1.04%	.04%

Modernization of blood banks

The National AIDS Control Organization has launched a central scheme of assistance to states to upgrade and provide minimum facilities to all blood banks in the public sector and also a number of blood banks run by charitable organizations.

Blood Banks Modernized

Year	Major Blood Banks	Distt. Level Blood Banks	Total
1989-92	138	Nil	138
1992-93	98	80	178
1993-94	Nil	100	100
1994-95	Nil	100	100
1995-96	Nil	100	100
1996-97	Nil	207	207
TOTAL	**236**	**587**	**815***

* Govt. - 727; Charitable - 38

This assistance includes blood bank equipment and contingency grants for the purchase of consumables, chemicals a reagents. Out of a total of 1475 blood banks run by the Government, Private, Voluntary and Charitab organizations, in all 815 blood banks have been modernized in phases during the Seventh and Eigh Plan as per details alongside.

Rational use of blood

Blood Component therapy is appropriate and effective as it gives the patient only what the patient needs and blood components harvested from a single unit of blood can be used for various purposes, thus optimizing the use of the same unit of blood.

The requirement of blood in the country, assessed on the basis of number of hospital beds with a criterion laid down by WHO of 6 - 16 units (Avg. 11 units) of blood per hospital bed, is estimated as 60.00 lakh units per annum. There is, therefore, an over all shortage of blood to the extent of 50% at the existing level. It is likely that the shortfall will increase by about 40.00 lakh units by the end of the Ninth Plan. The gap between demand and supply is continuously being widened by inappropriate use of blood. Nearly 30-60% of unnecessary transfusion indicates a need for awareness of clinicians. While orientation of the clinicians is an important thrust area, the National AIDS Control Organization, have set up the target to provide Component Separation Facilities by establishing 40 Component Separation Units all over the country. These centres will provide the much needed components. The doctors and technicians working in these component labs have been duly trained at KEM Hospital, Mumbai. National guidelines for appropriate use of blood have been prepared and are being widely circulated.

One Plasma Fractionation Centre has already been set up at KEM Hospital, Mumbai and additional such units would be set up later.

Training and manpower development

There is an acute shortage of trained manpower for working in the blood banks. One of the reasons being that there is no special cadre for medical and paramedical personnel to work in the blood banks. At the same time there are no special training programmes available in the country. The Government identified 10 regional training centres for conducting short-term training courses for in-service training of personnel. Modular training is already in progress.

The Medical Council of India has recently recognized Transfusion Medicine as a speciality and proposed an MD course in this. One centre at Lucknow has already started the MD course in Transfusion Medicine and three other centres have started a Diploma course. It is contemplated that with the approval ot the Blood Transfusion discipline as a distinct speciality, many more centres would come up and we shall be able to have large number of personnel trained in the field of Blood Transfusion. The task is, however, gigantic and it would take quite some time before we are able to create the required trained manpower for our blood banks.

Legal framework

An adequate legal framework has been provided in Schedule XII B of the Drugs and Cosmetics Act/Rules , which stipulates mandatory testing of blood for Blood Transmissible Diseases, including HIV. The rules have been recently amended providing for adequate testing procedures, quality control, standard qualifications and experience for blood bank personnel, maintenance of complete and accurate records,

etc. The Drugs Controller General (India) is the Central Licence Approving Authority whereas the regulatory control remains under the dual authority of the State and the Central Government. The blood banks under the Act require a manufacturing licence. The status of licensing of blood banks is as follows:

LICENSING STATUS.OF BLOOD BANKS AS ON 30th APRIL, 1997

Managed by	Total	Licensed
Government	485	391
Private	565	427
Total	**1050**	**818**

Promotion of voluntary blood donation

For generation of blood through voluntary blood donation programme, the Government of India has taken a number of steps as follows:

1. A campaign has been launched through television by specially developed TV spots, telecast through Doordarshan at suitable intervals during prime time, for motivating people to donate blood voluntarily.

2. Messages on voluntary blood donation are broadcast through Times FM channel in one of their music programmes.

3. NACO with the help of the Central Health Education Bureau have developed prototype IEC material for one to one communication on voluntary blood donation programme in the form of folders, posters, and stickers and the same have been given to various states and UTs for use and reproduction in the vernacular languages.

4. The National Council for Science and Technology Communication (Deptt. of Science and Technology, Govt. of India) have initiated a pilot intervention project for generating voluntary blood donation in 50 selected cities, with a view to fill the gap between demand and availability of blood.

"The cornerstone of a safe and adequate supply of blood and blood products is the recruitment, selection and retention of voluntary, non-remunerated donors. Recruiting donors is not safe, practical or cost-effective unless one ensures that they are from population groups with the lowest risk of infection. However, any information obtained during the recruitment and selection of donors is strictly confidential. It must never be used as a basis for stigmatization or discrimination in the community."

Dr. Jean Emmanuel, Chief, Blood Safety Unit, WHO.

5. Every year, the 1st of October is celebrated as the National Voluntary Blood Donation Day. Special campaigns to educate the masses and special camps for blood collection are organized. Messages from the President of India, the Prime Minister and Minister of Health and Family Welfare with appeals for voluntary blood donation are telecast and broadcast. These messages also appear in newspapers.

Supreme court judgement on revamping blood banks

In a Public Interest Litigation (PIL), the Supreme Court of India, in a historic judgement on 4th January, 1996, directed the Union of India and State Governments to take various steps towards coordinated management and revamping of blood banking activities in all its facets of collection, testing, quality control, storage, archiving, rational use, monitoring, training and research. Some of the directives of the judgement are:

a) The Union Government and all the State Governments/UT Administrations shall establish National/ State Blood Transfusion Councils by 15th July, 1996, as a 'Society' registered under the Societies Registration Act, 1860. The Object Clause of the Constitution of the Councils assigns the task of ensuring coordinated management of blood banking services in all its facets.

b) To licence all the blood banks by 31st Dec.'96 (later extended to 17th May '97).

c) To take steps to discourage the prevalence of professional donation of blood so that the system is completely eliminated by December 31, 1997.

d) To secure a grant of 100% exemption from Income Tax to the donors in respect of donations made to the National/State Blood Transfusion Councils.

e) To consider the advisability of enacting separate legislation for regulating the operation of blood banks.

The judgement provides a good tool for revamping the Blood Transfusion Services ensuring adequate availability of safe blood and blood products. The follow up of the judgement was the formation of the **National Blood Transfusion Council** in May, 1996. **State Blood Transfusion Councils** have also been set up in all the states and UTs. Section 80-G of the Income Tax Act has also been amended by the Government to provide for 100% deduction from total income to the donors in respect of donations to the National and State Councils. The operationalization of blood banking activities have also been covered under the Drugs and Cosmetics Act/Rules, which are in the process of revision.

Summary and Critical Analysis

Under the Blood Safety component of the National AIDS Control Programme, the Government have endeavoured to revamp the Blood Banking Services by providing the much needed inputs towards setting up of HIV testing network and contingent expenses for day to day working of the blood banks; in-

service training to personnel working in the blood banks; setting up of blood component separatio facilities and one Plasma Fractionation Centres for making the safe blood components and blood product available. The task, however, is far from completed. The areas which still need to be covered are:

Role of the State Governments

Setting up of Blood Banks is the responsibility of the State/UT Governments. The Nationa Blood Safety Programme assumed availability of basic infrastructure for all the blood banks taken up fo modernization and setting up of testing facilities. The State Governments have not only to ensure tha this basic infrastructure is available, but also, to ensure total and coordinated management, includin formation of cadres for both medical and paramedical personnel.

Role of NGOs

There are a number of Non Governmental Organizations (NGOs) in the country which are primarily engaged in the task of generating blood from voluntary donors. Their activities will need to be coordinated.

Voluntary Blood Donation Programme

Since we have to put a stop to the commercial blood donation system, steps will have to be taken to mobilize the mass media and to establish a one to one communication in a big way, at the same time ensuring infrastructural support and safety.

Statement Showing Modernization of Blood Banks and Blood Component Separation Facilities (BCSF) by NACO:

Sl. No.	Name of State/UT	Govt. Blood Banks	Charitable/ Voluntary Blood Banks	Total	BCSF
1	Andhra Pradesh	54	6	60	1
2	A & N Islands	2	-	2	-
3	Arunachal Pradesh	5	1	6	-
4	Assam	18	-	18	-
5	Bihar	49	2	51	3
6	Delhi	14	-	14	4
7	Dadra & Nagar Haveli	1	-	1	-
8	Daman & Diu	1	-	1	-
9	Gujarat	48	7	55	4
10	Goa	2	1	3	-
11	Haryana	17	1	18	1
12	Himachal Pradesh	9	-	9	-
13	Jammu & Kashmir	13	-	13	1
14	Karnataka	42	10	52	1
15	Kerala	28	7	35	4
16	Lakshadweep	1	-	1	-
17	Maharashtra	65	6	71	6
18	Manipur			3	-
19	Madhya Pradesh	49	-	49	3
20	Meghalaya	3	-	3	-
21	Mizoram	4	-	4	-
22	Nagaland	3	-	3	-
23	Orissa	17	28	45	-
24	Punjab	22	10	32	1
25	Pondicherry	2	-	2	-
26	Rajasthan	17	1	18	1
27	Sikkim	2	-	2	-
28	Tamil Nadu	88	5	93	3
29	Uttar Pradesh	68	-	68	6
30	Tripura	6	-	6	-
31	West Bengal	71	3	74	1
32	Chandigarh Admn.	3	-	3	-
		727	**88**	**815**	**40**

STATUS OF MODERNIZATION OF ZONAL BLOOD TESTING CENTRES AND BLOOD COMPONENT SEPARATION FACILITIES

INFORMATION, EDUCATION AND COMMUNICATION

Highlights of 1996

- A major unified multimedia campaign planned for which a full range of IEC materials were prepared and will be implemented in 1997.
- To monitor and ensure the quality of telefilms and serials an in-house committee was setup to vet proposals submitted by private producers to Doordarshan and NACO.
- Proposals for production of 30 telefilms and 7 teleserials on HIV/AIDS approved of which 4 telefilms and 3 teleserials were telecast.
- An evaluation study of the AIDS awareness activities of DFP was initiated.
- Prevention Indicators survey conducted in five states.
- A Behaviour Sentinel Surveillance survey conducted in Tamil Nadu to establish benchmarks.
- NACO directly supported 28 NGOs to implement the AIDS awareness activities as well as targeted intervention projects.
- An IEC package and blueprints of intervention projects based on research prepared for street children in 4 major cities.

In the absence of a preventive vaccine or cure for HIV/AIDS, an effective and sustained strategy to bring about changes in behavior to prevent further infections is the highest priority. Creating an "enabling environment" to facilitate behavioural change through a network of information, education and communication (IEC), as well as services, empowers individuals and communities to adopt safer practices and to handle, with sensitivity and care, people already suffering from HIV/AIDS.

However, bringing about a behavioural change is a difficult and protracted process. The task is complicated by the sensitive and personal nature of the issues, belong as they largely do with sex and sexuality. Effective IEC for HIV/AIDS must, therefore, use a full range of approaches and activities, from mass media campaigns for public education, to the use of targeted interpersonal communication to help negotiate safer practices for groups at particular risk of the infection. The role of electronic media, because of its easy mass reach, to inform and establish positive norms among the general population, must be stressed. Public education can be particularly effective in clearing misconceptions and ignorance about HIV/AIDS and creating a positive social environment without discrimination and stigmatization. However, IEC programming cannot be effective in isolation. It must not also, stagnate as a one-way communication system. This is specially important when designing programmes for vulnerable populations not easily accessed by information and services. In addition, the cultural and linguistic diversity of our country demands that the IEC approaches and materials to have specific relevance, must be adapted for every cultural and linguistic context . Integrating the IEC strategy into the other ongoing components of the National AIDS Control Program, such as STD services, condom programming and blood safety is essential to the success of the program as a whole.

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DOCUMENTATION

Current Knowledge and Attitude towards AIDS

Efforts have been under way in many parts of the country to educate people on AIDS, it transmission and prevention. To support those efforts, a number of small studies with targeted population have taken place to ascertain current knowledge, attitudes and practices related to AIDS and STDs These include studies by the Department of Family Welfare, NACO, National Service Scheme, Tat Institute of Social Sciences and some market research agencies. Quantitative and qualitative studie have been conducted among street children, youth, students, injecting drug users, truckers, sex worker and clients of sex workers. Although these studies are limited, an eclectic usage of the findings of thes gave baseline information on which initial programs were launched. The following statements, howeve held true for the most part:

- Most individuals do not have accurate, complete information on AIDS.
- The direct links between STDs and AIDS is not clear to most people.
- STDs are not perceived as serious conditions since they are curable.
- There is a belief that HIV transmission and AIDS is found in only limited groups, such as foreigners homosexuals, prostitutes and drug users.
- The IEC campaigns and targeted interventions have demonstrated changes in knowledge, perceptio and behaviour.

Objectives of IEC

The overall objectives of the IEC programme are:

- to raise awareness, knowledge and understanding among the general population about AIDS, HI infection and STDs, routes of transmission and methods of prevention;
- to promote desirable practices, such as avoiding multiple partner sex, condom use, sterilization needles and syringes and voluntary donation of blood;
- to mobilize all sectors of society to integrate AIDS messages and programming into existing activitie
- to train health workers in AIDS communication and coping strategies and thereby strengthen technic and managerial capabilities.
- to create a supportive environment for the care and rehabilitation of persons with HIV/AIDS.

IEC Strategies

The IEC strategic plan for AIDS prevention and control in India involves the use of a wid spectrum of communication strategies for awareness, behavior change and social mobilization. Thes include:

1. Mass Media
2. Advocacy at various levels
3. Intersectoral collaboration
4 Training
5. Involvement of NGOs
6. Counselling
7. Research

To achieve these goals, the IEC team at the central NACO office, headed by Addl. Project Director with the overall duties of guiding the activities of NACO on IEC, comprises of one Deputy Director(IEC), one Under Secretary, one Health Education Officer, and one National Consultant.

A comprehensive IEC strategy was prepared in 1994, which is being operationalized both at the national level and by the States and Union Territories.

The central NACO office provides basic information on HIV/AIDS, policy decisions, and broad guidelines on information, education and communication strategies. Generic material is developed at the central office and disseminated to the States and UTs, NGOs and the media. Activities aimed at raising awareness of the general public, using TV, radio, press and other appropriate channels of communication have been operationalized. Given the population size and the cultural diversity of India, the messages and media material are used by states and NGOs keeping in mind the regional nuances.

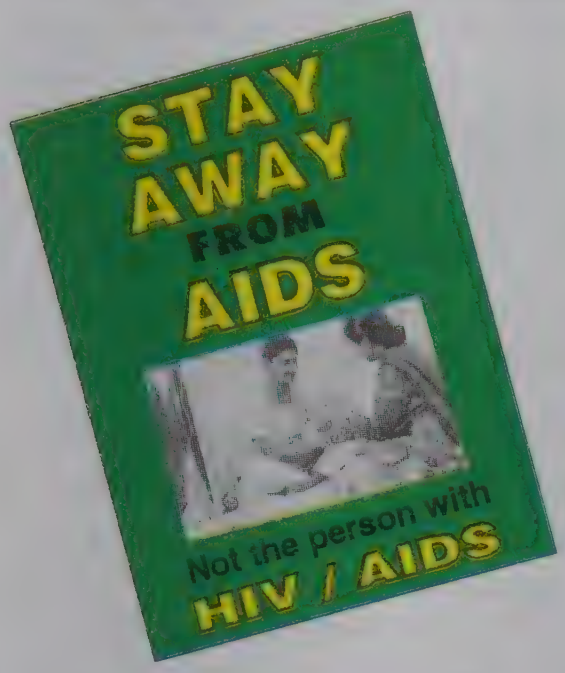
NACO undertook an assessment of the quality of existing IEC material produced both by NACO and State AIDS Cells (SACs). With regard to the SACs material, the assessment indicated that: the basic facts on HIV transmission and prevention were largely covered; many states used the same messages and visuals in different material for reinforcement and recall; the quality of presentation varied considerably; some materials were not gender sensitive and messages tended to be moralistic; and factual inconsistency was seen in some materials. The NACO materials were found to be good in respect to factuality, but some had arrested quality in terms of movement of messages from awareness to needed behaviour change. Quality variation was also found in audio-visuals. However, the generic IEC packages for special target groups were marked by completeness as these were developed after research and field testing.

Multimedia Awareness Campaigns

The use of the electronic media such as radio and television has been the mainstay of the IEC strategy as its reach is vast, immediate and cuts across the literacy barrier. The use of the electronic media has been underpinned by a press campaign, both at the national and regional levels. Interpersonal publicity through field publicity units and video vans has been used to reach out to those beyond the span of press, radio and TV.

- A major media blitz was planned in 1996, for which a private advertising agency was engaged for designing generic materials for a unified multimedia umbrella campaign and providing designs of posters, pamphlets, booklets, newspaper advertisements, films, TV spots, radio spots, wall paintings and cinema slides. These materials are being brought out in Hindi, English and 11 regional languages, thus ensuring quality and correctness of the messages. The drafts and scripts of these materials were reviewed by a technical committee and finalized for production. Some of the campaign materials

like TV spots and press advertisements have already been telecast/broadcast. Two focussed multimedia campaigns were implemented: one on the World AIDS Day and the other on the National Blood Donation Day. These campaigns were supplemented by a wide range of activities undertaken by state governments, social institutions and NGOs. The campaign contributed to the social mobilization effort to a considerable extent.



IEC Material Developed

- NACO, in 1996, placed from its budget with the Ministry of Information and Broadcasting for each of the six media units. NACO also organized workshops and briefing sessions for these units to ensure appropriate sensitization of the programme officers.

- The Directorate of Advertising & Visual Publicity (DAVP) produced more than a dozen video spots and jingles. These, along with two TV spots produced through the advertising agency, were telecast for three months on a regular basis over Doordarshan. They also released a series of press advertisements for the World AIDS Day.

- In January 1996, in order to monitor and ensure the quality of telefilms and serials, NACO set up an in-house committee to vet proposals submitted by private producers to Doordarshan or to NACO directly. Two tele serials and seven telefilms were telecast. About two dozen more telefilms and six serials are currently at various stages of production.

- More and more radio stations have begun to organize programmes on AIDS. These include radio serials, panel discussions, talks, features, phone-ins, dramas, and so on.

- The Song and Drama Division has developed a programme of street plays, songs and dramas which were performed in about 400 locations in the urban areas of 10 states/UTs in 1994. These activities were extended to more states during 1995-96. A private professional agency supplemented these efforts in 10 selected states.

- The Directorate of Field Publicity's 260 countrywide units have all held AIDS awareness activities

which include seminars, debates, essays, quiz competitions and film shows.

- The Press Information Bureau of the Government of India organized workshops to sensitize the regional press on the issues of HIV/AIDS.

Private Radio Channels

- NACO has also involved private radio channels. The Times FM programme "NACO Film Hit Parade" was very popular during 1994-95 and it was resumed in 1996. This is a music programme in which AIDS messages and information are given by the compere.

IEC Print Material

The following special packages of IEC material have been produced for specific vulnerable population groups for use by outreach workers, health workers and peer educators of government organizations and NGOs.

- A package for injecting drug users in the Northeast comprising two sets of flash cards, five posters, five stickers, four leaflets and a guide book for its use.

- A health education package for the commercial sex industry comprising three sets of flash cards, one poster, one leaflet and a user manual.

- A package on voluntary blood donation containing print and audio material was developed by Central Health Education Bureau.

- A package on HIV/AIDS containing three posters, a flip book and a folder has been produced for slum dwellers.

- An IEC package has been produced consisting of posters, booklets, stickers, a video and a set of options for work place education in industry.

- An imaginative package containing training guides, posters, educational games and kites has been developed for street children.

Intersectoral Collaboration Through Advocacy

AIDS is not merely a medical problem, but a multi-faceted issue and is a threat to the fabric of society. The health sector alone is not sufficient to combat the problem. All sectors must get involved to broaden the front against the spread of HIV/AIDS. It is necessary to convince numerous policy makers, programme managers, leaders of business and industry and opinion leaders of the seriousness of the AIDS epidemic and of the need for securing their commitment to prevention of AIDS and human rights

of those afflicted. One major strategy is to tap the networks available within the government sector and to tap private sector networks and resources available in associations, organizations and in the industrial sector. Every possible network should integrate AIDS programming into their agendas.

Advocacy Activities and Plans

- Orientation sessions and meetings were held with Government and Non-government media - Doordarshan, AIR, DAVP, Song and Drama Division, Directorate of Field Publicity, Films Division, Press Information Bureau (PIB), and Times FM to prepare advocacy packages specially relevant to these media.

- Advocacy meetings were held with Railway Board, P&T, Defence Services, Paramilitary Forces (CRPF, BSF), ESIC, Indian Medical Association, Nursing Council and other agencies involved in social services.

- Five workshops were organized in collaboration with Ministry of Welfare and international agencies with 80 NGOs on "Reducing Risk Taking Behaviour Related to HIV/AIDS/STD and Drug Abuse Among Street Children".

- Two advocacy workshops were held for policy makers and programme implementors in collaboration with the Delhi Government.

- NACO continued to organize activities in observance of the World AIDS Day (December 1) and National Voluntary Blood Donation Day (October 1), and to support NGOs and social institutions on these occasions.

- Workplans of the Department of Family Welfare have already integrated HIV/AIDS in IEC materials preparation, while the Ministries of Information and Broadcasting and Human Resource Development have disseminated HIV/AIDS/STD related messages at a large scale.

- The Ministry of Welfare has agreed to incorporate HIV/AIDS/STD and drug abuse in street children projects. It has also collaborated with NACO, UNDCP, UNICEF, WHO, UNAIDS in a study of risk taking behaviour among street children and development of IEC package.

- In a meeting chaired by the Secretary, (Labour), the Director General (DG) Employees State Insurance Corporation (ESIC) and DG of Employment and Training agreed to incorporate STD/HIV/AIDS issues in the ESIC dispensaries, industrial training institutes, trade unions leadership courses and workers training activities.

- Some initiatives taken by the Department of Youth Affairs and Sports, Ministry of Human Resource Development are presented below:

Nehru Yuva Kendra (NYK)

- NACO is supporting a programme to reach rural youth through a network of 700 NYKs for spreading awareness on family life education, responsible attitudes to sex and safer sex options.
- Workshops have also been held with the NYKs in the Northeast to integrate AIDS/STD into their programme activities.
- A conceptual framework for incorporating HIV/AIDS/STD in a countrywide perspective plan for non-student youth has been developed and accepted.

Outreach Projects

In order to reach the rural areas, the Department of Youth Affairs and Sports also organized a multimedia workshop using rural art forms to disseminate information on HIV/AIDS. Over 70 artists, practising various art forms like puppetry, magic, Harikatha, Qawali, Nautanki, folk dance and music, participated and developed messages. These are being used in outreach activities of NSS and UTA.

Universities Talk AIDS

It has been recognized that youth and schools, colleges and universities are increasingly at risk for drug abuse, sexually transmitted diseases, unwanted pregnancies, and now AIDS. Therefore, the need for education for preventive behaviour and health care is imperative. The Department of Youth Affairs and Sports, Ministry of Human Resource Development, has taken a pioneering lead in AIDS prevention and control among youth with a programme entitled "Universities Talk AIDS" (UTA) implemented by the National Service Scheme (NSS). Initiated in 1991, with assistance from WHO, the programme has geared up to reach all major universities and +2 level schools collaborating with the NSS in the country with technical and financial support from NACO. They have produced a series of IEC material for students. The NSS has completed a training module for students on AIDS and sexuality and has implemented a national programme through their network. The manual has been translated into seven languages and is in its fourth edition. NACO has provided intensive technical assistance.

UTA Evaluation

1. The UTA has been successful in creating considerable awareness on HIV/AIDS among student youth in schools, colleges and universities. 3.5 million students have been made aware about AIDS and 4044 institutions have been covered.
2. UTA has developed good understanding between the sexes and fostered positive attitudes and responsibilities towards HIV/AIDS.
3. To educate fresh entrants to schools and colleges there is imperative need to sustain the UTA programme.
4. More educative and thought provoking material exclusively for the youth needs to be developed.
5. There should be full time staff to look after UTA at the national level.
(UTA program was evaluated by WHO, MCRC Jamia Milia Islamia, Social and Rural Research Institute)

Vishwa Yuvak Kendra (VYK)

NACO has funded Vishwa Yuvak Kendra, which trained NGOs working with youth in seven major Indian cities. The Patna affiliate of VYK trained non-student youth leaders.

AIDS Education in Schools

Recognizing the fact that young people in India, as in most countries, are especially vulnerable to HIV infection, NACO assisted in preparation of projects for introduction of "AIDS Education in Schools" in 17 states and UTs. These projects were prepared in consultation with National Council of Educational Research and Training (NCERT) and the concerned State Councils for Educational Research and Training (SCERTs) or State Institutes of Education (SIE) in 1995. These projects generally have four components:

- material development/adaptation;
- training of teachers;
- student activities; and
- monitoring and evaluation.

Prior to the formulation of these projects, a training package titled "AIDS Education in Schools" was prepared in consultation with NCERT, UNESCO and other international agencies. This training package advocates co-curricular or extra-curricular approach since integration of AIDS education in the school curriculum would have taken much longer time as curricular change is usually a long drawn process. The funds for implementation of these projects were released to SCERTs/SIEs by NACO through the State AIDS Cells. The Government of Maharashtra had already been implementing the programme at a much larger scale. The implementation of these projects was reviewed by NACO in March, 1996. The review indicated that about half of the projects had started in right earnest whereas the other half had yet to be undertaken in all their components.

Some reactions of adolescent girls on the need for Sex Education in Schools

"When we're growing up we stop discussing things with the boys like we used to. We think we know what they are thinking about - and we think they think they know what we're thinking about. It's all a big mess - but if we want to talk, people want to know what we are talking about and then we have to lie and say we were discussing studies."

--Elizabeth, Class XII

"The teachers get angry if we sit next to the boys. My parents get angry if a boy telephones me. Can't they understand we like being friends - and that doesn't mean he's my boyfriend or I'm his girlfriend ?"

-- Deepthi, Class XII

"Yes, these topics (*reproduction, etc.*) are there in the textbook. But our teacher just read it out - we thought she seemed terribly embarrassed - and that made us feel embarrassed. We didn't understand a lot of things - but we couldn't ask. And not all of us can go home and talk to our parents about it."

--Sushma and Michelle, Class XI

"We should be able to discuss these things in Class IX."
"No, Class VIII would be better."
"And it must in a group of boys and girls. We want the boys to understand us."
"And we have to understand them."

-- A group of girls in Class X

(Courtesy: `AIDS and Human Sexuality - Needs of Adolescent Girls' by Dr. Janaki Sankaran. Newsletter, NACO, March 1995)

Alongside, NCERT, in consultation with NACO and other agencies, has been working on developing a scheme of introducing "adolescence education" in the formal school system. This would be done by adding it to the subject of Population Education, which is already there in the school curriculum. Adolescence Education would have three components, process of growing up, AIDS education and drug abuse. The component of "process of growing up" would include critical issues related to the growth of a child into adulthood - physical aspects, social aspects, sex roles, STDs, etc. The contents of the three components have been worked out in the form of separate curricular units at the various stages of school education in a graded manner which means that at the primary stage, the contents will be of very preliminary nature and more detailed information is added to the subsequent stages. The approach to integrate this would be both curricular and co-curricular.

The Department of Family Welfare has supported incorporation of HIV/AIDS into all population education projects being monitored by them.

Women

Two workshops have been held to examine the issues surrounding women and AIDS; one with grass-roots women's organizations and the other with women's studies centres. The objective was to mobilize women's organizations and orient them towards these issues. The March, 1995 edition of NACO's newsletter was dedicated to women and AIDS.

Industry

Meetings and seminars have taken place with the Federation of Indian Chambers of Commerce and Industry (FICCI), the Confederation of Indian Industries (CII) and the West Bengal Chamber of Commerce. NACO and WHO supported CII in developing an advocacy and options package for work place AIDS education.

Involvement of NGOs

The involvement of NGOs in the AIDS prevention and social mobilization is of vital importance. It has been the policy of NACO to encourage and provide technical and financial support to NGOs to implement AIDS awareness activities as well as targeted intervention projects for behaviour change. NACO directly supported seven NGOs in 1994-95, six in 1995-96 and 28 in 1996-97. All states and UTs have been authorized to sanction NGO projects with enhanced financial limits.

- To facilitate greater involvement of NGOs, guidelines for preparing and writing project proposals have been revised and circulated to state governments. Guidelines have also been prepared for appraisal of NGO proposals by the State AIDS Programme Managers. Further, guidelines have also been prepared for planning intervention projects for use by NGOs. These guidelines are under print and would soon be available for distribution.

- A central level NGO was identified which provided training to NGOs operating in different parts o the country from 1994-1996.

- NACO is providing technical and financial support to HIV positive people to form organizations o their own.

- Based on the experience of a project for the care of HIV infected/AIDS individuals in Manipu guidelines on "Continuum of Care" were developed and projects have been designed in Tamil Nad and Maharashtra.

Counselling

Counselling, face to face interpersonal communication, is perhaps the most powerful tool to effec behavior change, particularly when it relates to sex practices. Counselling is a vital strategy, particularl in targeted intervention projects where we deal mainly with people practicing high risk behavior. Throug counselling people can be made to scrutinize their behaviour and persuaded to negotiate safer practice to protect themselves from getting infected. If they are already infected, they can be helped to cope u with the trauma. Counselling is essentially a problem solving process in which one is made to explore a the options available and make the best suited choice. In addition to those infected it can be of immens help for those taking care of the HIV infected. Counselling is an important input to the reduction o impact of HIV/AIDS on individuals, families and communities. It is discussed at a greater length in th chapter on "Reduction of Impact".

Training

All categories of government workers need to be trained on the facts of HIV/AIDS. For healt care workers this also entails facts on how to protect themselves and how to provide compassionat treatment to those affected. The following activities have been undertaken:

- A training module has been produced for IEC and AIDS, and adaptation of IEC material. Thi module has been used by several NGOs in training grass-roots level workers.

- A training module for nurses has been developed. A few states are considering its adaptation t initiate training programmes.

- An IEC Planning training module for the State AIDS Programme Managers has been prepared an two training courses for these officers from nine states were held using this module.

Research

Studies and surveys regarding attitudes, perceptions of Indians towards sexuality, condom use and their level of awareness about STD and AIDS is important for guiding and directing policy make and planners. A number of studies were done to identify potential link areas.

High risk behaviour survey

A high risk behaviour study was planned to be conducted in 65 major cities and towns covering all the states and UTs. Studies have been completed in 36 cities covering 6 states and 2 UTS. The delay in other states is due to non-availability of suitable institution and other technical difficulties.

The purpose of the study was to map the prevalence of high risk behaviour in groups like sex workers, men having sex with men, trans sexuals/eunuchs, frequently travelling males, injecting drug users and slum dwellers. The salient findings are:

1. The reports reflect a unique and special pattern of behaviour for each city, though there are commonalities cutting across the cities and regions.

2. Certain high risk behaviour groups are difficult to locate than others. While commercial sex workers, truck drivers, slum dwellers and street children are very visible and easily accessible, men who have sex with men and injecting drug users have carefully cultivated invisibility for their own survival. Access to one group of the member does not necessarily extend to access to others.

3. The patterns of behaviour are varied. Each group has a different social framework within which it operates. The reports describe heterosexual as well as homosexual patterns, both in commercial as well as outside the commercial sex work circuit. Various situations and settings which contribute to the high risk behaviour have been narrated and the sites mapped.

4. Issues related to behaviour change and intervention planning and design range from personal/ professional factors, socio-economic factors, structural factors, condom usage to health care seeking behaviour.

5. The need to take a broader perspective which encompasses the overall conditions and problems has been underlined in all cities. The all pervasiveness of harassment by the police, the inadequacy or irrelevance of health services, hypocrisy in society as well as effects on the low status of women were issues that emerged universally.

6. A high level of denial of the problem was found not only in the general population, but also in the concerned health functionaries.

7. The positive features of the survey are: the process of data collection has resulted in a greater awareness and commitment by officials and local NGO; and building up of research teams which have enthusiasm, commitment and strong motivation to continue working with a deep empathy for the persons they work with and the problems faced by them.

A large amount of information has been collected which would be utilized for constructive actions. An advocacy package has been developed, based partly on the findings of High Risk Behaviour Surveys conducted in different cities. National and regional level institutions/agencies will be identified to undertake advocacy activities for both policy makers and implementors in the states.

Other Research Projects

- A **Prevention Indicators Survey** encompassing urban and rural areas of five states has bee conducted. The findings of the survey will be used for future planning.

- A **Behaviour Sentinel Surveillance Survey** to establish the benchmark was conducted in Tam Nadu under the AIDS Prevention and Control Project. The methodology and findings would b shared with interested agencies and organizations. The survey is proposed to be repeated on a annual basis.

- A professional agency has been commissioned to conduct a qualitative as well as quantitativ survey regarding knowledge and understanding of HIV/AIDS/STD, perception of condom and condon use in urban areas of several states. The survey is half way through.

- An evaluation study of the AIDS awareness activities of the Directorate of Field Publicity has bee initiated.

TARGETED INTERVENTIONS

Highlights of 1996

- NACO directly supported 28 NGOs to implement targeted intervention projects.
- Workshops held at Raxaul to identify more cross-border points for initiating intervention projects for truck drivers.

Introduction

Broadly, there are two behaviour groups, those practicing unprotected multi-partner sex and those injecting drugs, which are at a high risk of contracting and transmitting HIV infection. Many such localized groups are already showing high HIV prevalence while the rest are at the brink of becoming HIV infected. Such groups can be easily identified and a case-specific multi-pronged approach can be devised to contain further transmission of HIV within this group or to other strata of community through them, as also to give health care and support services to those already infected. A combination of IEC strategies, including counselling, and relevant service provision, such as STD care and condoms, can be used to help create an "enabling" environment for people to scrutinize their behaviour and effect a change in it to protect themselves. Targeting such high risk groups can make prevention a concerted community effort instead of individual struggle for existence.

Objectives

To reduce HIV transmission among population groups at increased risk of HIV infection through health promotion and education, and the provision of appropriate facilities and services.

Strategies

Baseline surveys and research

In order to identify the distribution and location of high risk groups, surveys have been undertaken in many parts of the country to collect information on prevalence of high risk groups, areas of concentration, their knowledge, attitudes and practices etc. Based on the informations received, an advocacy package is prepared for policy makers in states and implementors of STD/HIV/AIDS Control Programme. The package was first pretested from 12-14 Feb., 1997, at Delhi, and based on the feedback received from participants, further workshops are envisaged to be taken up in other states and UTs in the near future.

In addition to the above, prevention indicator surveys have been completed in 4 metro cities, of Delhi, Calcutta, Mumbai & Chennai, and in, 4 rural belts of Haryana, Tamil Nadu, Maharashtra and West

Bengal. The study was conducted on 8, different indicators, out of which, 2, are on STD and 6, are on HIV/ AIDS. The reports are being finalized, and further such studies are proposed.

Integrated Interventions - A Model

To most effectively reach groups of individuals practising high risk behaviours and to promote behaviour change, it is necessary to combine IEC and outreach strategies, condom promotion and provision of STD services and, where appropriate, counselling. Any one element alone will not have as

MODEL

PARTNERS IN INTERVENTION DEVELOPMENT AND IMPLEMENTATION

• Umbrella structure: Government or institution or NGO	Responsible for: overall management and coordination. This body must be able to initiate or develop health care services in the area, and bring all parties together. Government often has additional leverage through licensing and regulating powers.
• Communications expertise: Institute of Communications or NGO	Responsible for: the development of adaptation of targeted materials for the IEC component of the project.
• Collaborating institutions: eg. Institute of Social Sciences, Research Institutions, Medical Colleges	Responsible for: the implementation of specific components of the project, for instance, assessment, baseline survey, service provision
• NGOs: Community networks, social marketing organizations	Responsible for: direct access to target groups through networks, outreach work and interpersonal communication: social marketing of condoms.

PROJECT COMPONENTS:

1. IEC for behavioural change: promotion of condom use, improved health care seeking behaviour and reduced number of sexual partners;

2. Provision of clinical services for the management of STD, and to meet other health care needs in the community, integrated in the existing health care system;

3. Condom programming, to ensure the availability of easily accessible, good quality and affordable condoms.

great an impact as an integrated approach. An integrated approach to reaching truck drivers, for example, would necessitate availability of condoms, IEC approaches, STD services in a non-stigmatizing setting and possibly counselling services. No single organization can cover all these activities alone. HIV/AIDS/ STD prevention and control needs to be multi-sectoral to draw on a wide range of expertise and skills required in intervention development and implementation. This in turn requires close collaboration between government services, NGOs conducting outreach, and specialized institutions for research and communications. The following figure shows a possible model for an integrated approach:

Pilot Integrated Interventions

NACO has worked with WHO and other donor agencies in cooperation with state governments to conduct pilot programmes with identified groups using the integrated approach. These are outlined in the following:

Intervention in the Kamathipura and Khetwadi areas of Mumbai

Based on an initial assessment by a WHO consultant in early 1992, the Municipal Corporation of Greater Mumbai set up a targeted intervention for sex workers, clients and associated groups and the surrounding power structure in Kamathipura and Khetwadi, the major brothel areas of Mumbai. The intervention includes outreach activities, condom promotion and provision of STD services. Initially funded by WHO, the project is now supported by SIDA. A comprehensive external review, including evaluation and proposals for reprogramming took place.

Sonagachi Intervention Project, Calcutta

This project was initiated in September, 1992, with support from NACO/WHO (GPA), subsequently from NORAD and finally from ODA, based on random sample STD survey, conducted during May to June, 1992, the first such study in India. The project has 3 principal components i.e. provision of health services including STD treatment, Information, Education and Communication and Condom Programming. Currently this is supported from ODA, as a part of sexual health project in West Bengal.

It has been estimated that around 4000 sex workers reside in this locality, in nearly 370 brothels, with a seasonal variation of up to 1000. Depending on peak season in September to October around 1500 floating sex workers may also be found in the vicinity.

Objectives of the Programme

- To reduce the incidence of STD and HIV infection among sex workers and their clients in the target area through adequate provision of health services.

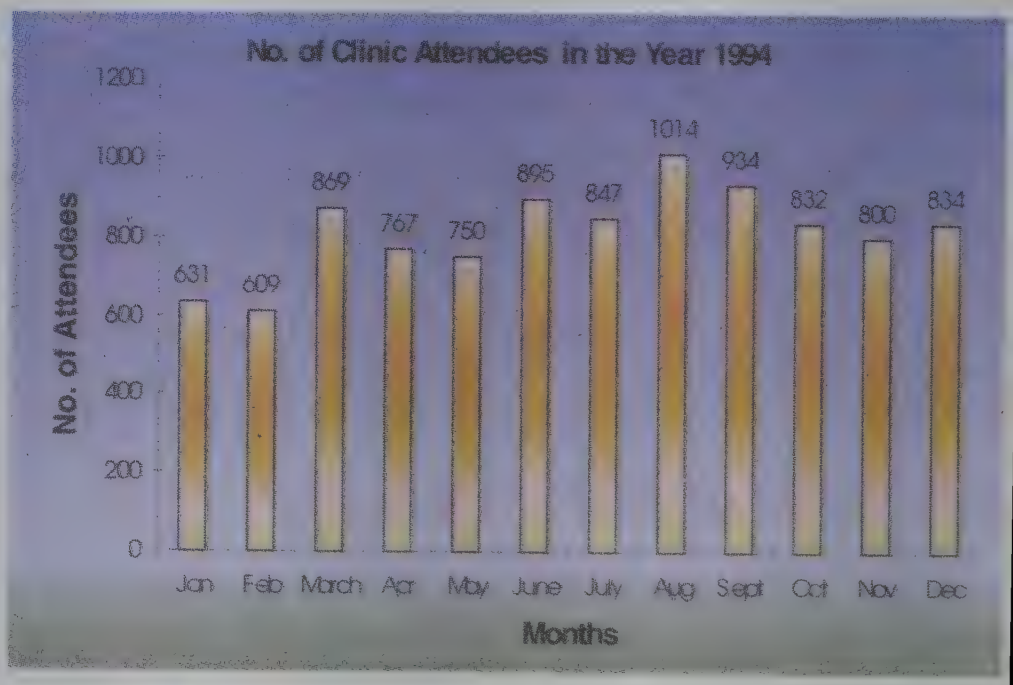
- To develop and implement appropriate laboratory support services for STD case management.

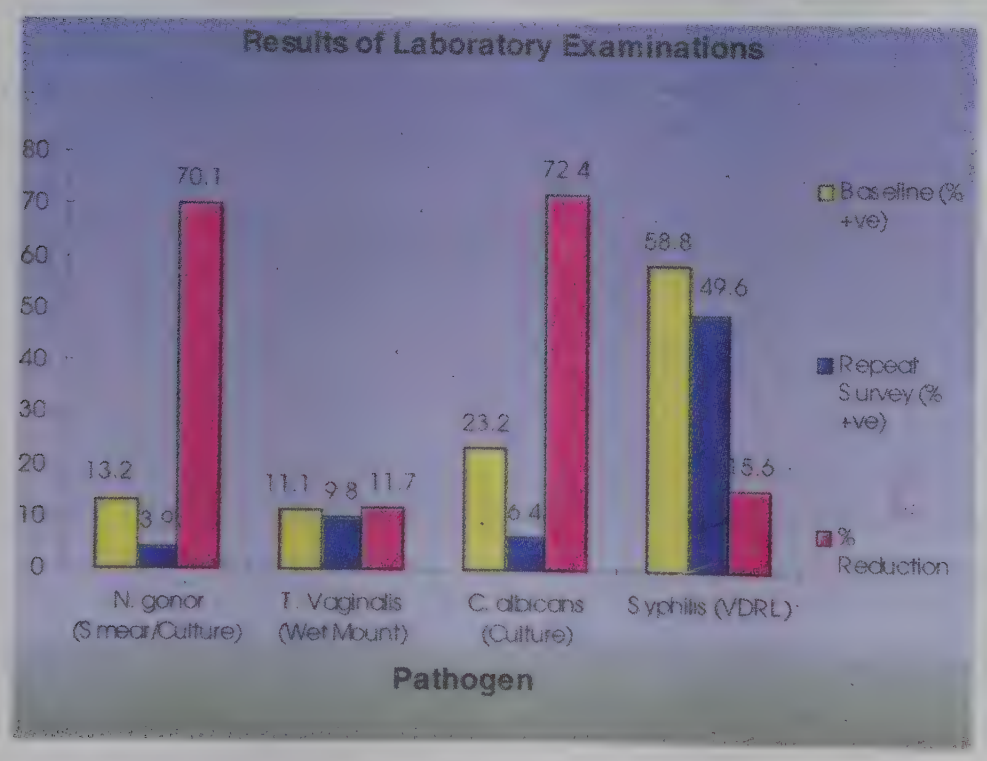
- To provide an entry point for education and awareness raising activities and for condom promotion among the focus groups.
- To maintain and expand the correct relationship of trust and confidence established between the implementors of the project and the community to generate support for AIDS prevention programme.
- To increase the awareness of HIV/STD/AIDS among sex workers, Madams, pimps and clients.
- To motivate sex workers and clients to use condom for each sexual encounter.
- To develop generic guidelines for the progression of intervention in similar areas.

Major Components of Interventions Programme:

1. Provision of Health Services:

Generalized health service including diagnosis and treatment of STD are provided to the sex workers through two established clinics. When the clinic started, 168 patients attended in the first month, whereas, in December, 1994 the number had reached to 834 as per the table below. 70-80% of the clinic attenders are sex workers and their families, and around 30-35%, attenders were found to have STD, as may be seen from accompanying figure.





Further, as an impact of these intervention activities, reduction of various STDs as observed in baseline survey and repeat survey, may be seen from the accompanying figure.

2. *Information, Education and Communication*

A system of peer educators was initiated and 65 volunteers from among the sex workers were identified and trained for a period of around six weeks and were divided into 10 groups headed by trained supervisors and, each group are assigned specific areas for this purpose.

Shekhar

A 32 year-old man from Chennai, Shekhar has known he is HIV-positive since 1993;

"I was just another young man with a future to dream about. I was doing business and was well settled. But my family wanted me to get married and they chose a girl. A friend of mine told me about AIDS, but as I was a homosexual i had never had sex with a prostitute so I thought I couldn't get infected. But he told me that AIDS also spreads through sex between men. So I went to hospital for the test. I was never given any counselling, and after a week they just handed me the result - I was HIV-positive.

"At first I thought I was going to die that night, or in a week at most. I wanted to commit suicide. I didn't know how to face my parents, but I decided to go and tell my whole family. They all started crying, and my brothers threw me out of the house because they were afraid of being infected through me. My grandmother took me in, and for three months, I was given food through a window.

"Then a friend heard about me and informed his office, the Community AIDS Network (CAN). A counsellor visited my parents and explained how I could continue to live within the family. They accepted me again, and I started having hope again. I started going to CAN as a volunteer, and then joined the project as an outreach worker. I started going to the cruising places for men who have sex with men, and talking about STDs, AIDS and the need for condoms with anal sex.

"At first people did not believe me. They wouldn't even believe I was HIV-positive. So I started talking on the radio and television, and also to newspapers. The result was electrifying. Suddenly people realized that AIDS was not something distant, but was amongst them. I think I was the first homosexual in the country to publicly declare myself HIV-positive.

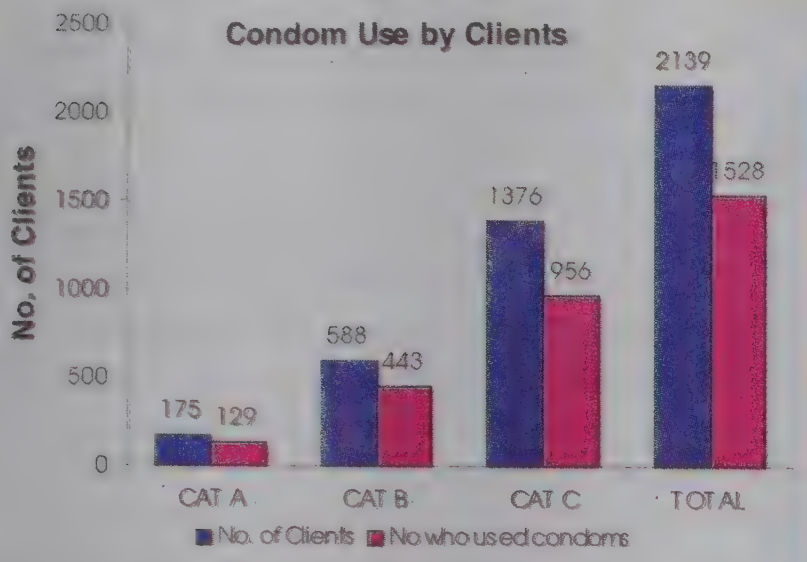
"But some people were angry, especially the *ali* (transsexuals) and men who sell sex to other men - they were losing clients because of me. But things died down. People started asking me questions about STDs and AIDS, condoms, and HIV testing. I started doing counselling at HIV testing centres, where I met more people with HIV, and we decided to form a support group called *Anbu Alayam* (`Temple of Love'). We support one another, and we also work for HIV prevention, especially by persuading people who test HIV-positive not to spread the virus deliberately out of a sense of revenge.

"My family has been ostracized because of me, but what does that matter compared with all those who will be saved from AIDS because I've come out into the open? I've received letters from many people who say that my life has been a lesson for them. That's what gives me the courage to go on. I am living my life positively and I will continue to contribute my bit in this struggle against AIDS."

(Case study courtesy: Broadening the Front' by Jaya Shridhar and Anthony Colaco)

3. Condom Programming

As a measure of propagation of safer sex practices, condom promotion constitutes an integral part of the outreach work and is also carried out through peer educators. The position of distribution of condom during 1994 may be seen from accompanying figure, whereas the position in respect of condom use by clients can be seen from the table below.



Categories A, B and C are graded according to the rates these sex workers charge their clients with A charging the most and C the least.

OTHER ACTIVITIES OF THE PROJECT:

In addition to the above, certain other promotive activities are also undertaken like-

1.Non-formal education

2.Immunization for the children of sex workers

3.Cultural programmes

4.Exposure to various social activities.

5.Usha cooperative multipurpose stores Ltd.- which plans to initiate self-employment and other vocational training schedules for the aged sex workers.

6.Legal training programmes.

Development of Strategies on Education on Safe Sex Behaviour for Sex Workers in Chennai

Unlike Calcutta, Delhi and Mumbai, there is no well demarcated brothel settings in many other cities of Indıa. In order to identify the approaches for intervention among CSWs outside brothels, a project was initiated in Chennai in August, 1992, where initially an assessment of the sex work industry and

AN INCIDENT TRIGGERS A CHANGE.....

IT was not an uncommon incident in a red light area. Yet the incident virtually opened up a new chapter in the ongoing HIV/STD intervention project being carried out by the All India Institute of Hygiene and Public Health in the city of Calcutta and Howrah.

It was just another day of slack business for Zarina, a commercial sex worker. She had nothing special , neither in her approach nor in her appearance. As usual, she was waiting in the street to solicit a client on a cold December evening. Unfortunately she could not manage to have a single client through out the day. It was a depressing day for her. When, with much despair and agony, she was about to leave the street, she found a client who almost instantaneously agreed to buy her service at a price of Rs. 50. Zarina took him to her room and requested him to use a condom. The customer declined , yet Zarina persisted. The customer walked out and headed for the local police station. Soon he was back with a police constable and Zarina was compelled to accompany back to the police station. There the police told her that she had to follow the dictates of the customer as the latter had paid her Rs. 50. The Rs. 50 was taken back from her. She was fined Rs. 60. Moreover, they scolded her for insisting on the use of condom.

On coming back to her room she received a volley of attack from her *Madam*. Zarina had no option but to spend a sleepless night without food. The next morning when she saw the peer educators and *Didis* (field supervisors) of the Institute, who were on their routine outreach activities, she stopped them and narrated the whole story. *Didis, a* bit puzzled, were not in a position to take a decision on this issue immediately. However, they tried to console Zarina in ways they could think of.

The aggrieved peer educators of the project spent no time to rush to the police station with a flip chart in their hands. They started showing pictures to whoever they met at the station starting from the officer-in-charge to *Daroga* who were on duty to make them understand the problem of AIDS and how to combat the menace through safer sex practices, including the proper use of condom. It was a unique venture, no doubt. The embarrassed police officers tried to avoid them in all possible ways, but could not get rid of them.

However, in the process the police commissioner of the city was contacted and a thorough discussion was held with him. He not only agreed in principle to the need and necessity of condom use by the clients of sex-workers but also extended all possible support to organize orientation cum training programme for the police officers of the city. As a sequel to these events the project team of the institute devised a curriculum for the police officers which included not only the technical aspects of AIDS transmission but also the importance of appropriate strategy to combat AIDS among the high risk groups, specifically the sex workers. During 1996 more than 180 police officers were trained who later provided support to the intervention project. A plan to train all rank and file of police dept. was prepared to commence in 1997.

(Case study courtesy Dr. Jana, All India Institute of Hygiene and Public Health, Calcutta)

underground network was conducted and then an integrated approach of outreach, condom promotion and liaison for STD services was developed. Findings from the assessment revealed a total sex worker population of 3000 with only 400 based in 70 to 100 small brothels distributed over the whole city. WHO has been providing financial and technical support to the research and intervention.

Men who have Sex with Men - Pilot Programme in Chennai

Following a situation assessment, an intervention programme among men who have sex with men (MSM) was inaugurated in Chennai on 15 March, 1994, by the Community Action Network with financial support from NACO. The inaugural meeting, accompanied by a musical programme with integrated AIDS messages was attended by over 600 members of MSM circuits and over 100 AI community members. The results of the assessment showed an alarming level of risky sexual contact between men, greater than had been expected.

Injecting Drug Users - Intervention in the Northeast

- NACO in collaboration with SIDA is supporting five NGOs in Assam, Manipur and Nagaland in conducting outreach interventions with injecting drug users. SIDA has funded intensive training of the five NGOs.

- ICMR with technical and financial support from WHO, is conducting operational research on outreach programming to prevent transmission through injecting drug use.

- OXFAM and SHARAN have linked up with NACO, WHO and the Government of Manipur and developed a model project on the home- or community-based care of persons with AIDS, called the Continuum of Care Project (discussed in greater detail in the chapter "Reduction of Impact").

- A project proposal from an NGO Community Health Action Network of Mizoram has already been approved with financial assistance from NACO to work for around 2000 injecting drug users at Aizwal and surrounding areas.

Major activities of the NGOs involved in Continuum of Care Project in Manipur:

- *Counselling Services for injecting drug users,*
- *24 Hour telephone helpline,*
- *To develop a care and support system spanning health care networks, homes and communities.*

Truck Drivers

1. A one year project for truck drivers on the Delhi-Kanpur and Delhi-Jammu highways was completed by SPYM, an NGO from Delhi, with success.

2. Another project for intervention amongst truck drivers has been completed at the Calcutta Port Trust and Ichhapuram (on the Orissa-Andhra Pradesh border) on the National Highway.

3. An intervention project for truck drivers started initially at Uluberia near Calcutta and subsequently, at Petrapole (on the Indo-Bangladesh border) around 100 Km. from Calcutta, was taken up as a 2 year project, by an NGO - TCI Bhoruka Welfare Trust, and was completed on 30-1-97. Further extension of the project is under consideration of NACO.

4. Based on a request to the ODA during 1993 and subsequent studies conducted by Indian Institute of Health Management Research (IIHMR) at Jaipur, a pilot project proposal is under finalization, with ODA assistance, which envisage establishment of around 30 major truck halt points, spread over the entire country with a provision for expansion.

   On completion of the pilot project, initially for a period of 18 months, and based on its success, a major substantive project is in the offing which proposes to establish around 300 truck halt points to be undertaken as per a planned strategy.

5. A project for truckers is now on at Raxaul (Indo-Nepal Border) with financial assistance from AIDSCAP. According to workshops, held at Raxaul in December, 1996, with eminent personalities and including international agencies, it is proposed to identify 4 more cross border points on the Indo-Nepal Border for initiating intervention projects for truckers, as well as for other high risk behaviour groups.

Activity Report (BAP, Raxaul)
(July 1995 - August 1996)

Take off Date	:	1 August 1995
Total Number of Interactions	:	6882
First Interaction	:	5338
Repeat Visits	:	1544
Total Number of Condoms Distributed	:	59504
Total Number of People Received Treatment	:	345
Total STD Cases	:	203
Total Other Cases	:	142
Total Number of Counselling	:	872
Total Number of Accident Insurance Cover	:	143
Number of Blood Testing	:	5

REDUCTION OF IMPACT

Highlights of 1996

- A counselling training project for countrywide coverage implemented.
- A complete training module in AIDS case management with emphasis on counselling circulated.
- A training module and guidelines for Primary Health Care Physicians completed.
- A comprehensive training manual for nurses completed.
- 600 teaching doctors trained for onclinical management of HIV/AIDS and basics of counselling in 20 workshops conducted countrywide.
- 429 out of the total 465 districts involved in training their medical officers in clinical management, diagnosis and counselling.

The HIV epidemic in India is still at an early stage with a high number of latent asymptomatic carriers of infection and our efforts are largely aimed at prevention to contain the spread. However, many families and communities will soon experience AIDS related illness and deaths.

Since HIV/AIDS is not merely a condition of ill-health, but a situation of great social and psychological upheaval for individuals, families and community, various quarters of the community and health care services will have to reorient their services to take care of and support those affected. Health care workers will have to develop special skills for taking care of those living with AIDS, while mobilizing the community to help those affected and their families and support the AIDS orphans. This is envisaged to be accomplished by:

- planning and training of the counsellors,
- setting up community based structures, and
- improving the access to health care facilities for those who are affected with HIV/AIDS.

For implementation of such activities, a coordinated effort by the Government, the private sector and the NGOs will be required.

Objectives

- To provide appropriate counselling services where needed to reduce social and psychological impact of the AIDS epidemic and for prevention of the spread of HIV infection.

- To ensure that health care workers are adequately trained to provide good quality care to patients with HIV and AIDS, and such care is not jeopardized by misconceptions and undue fear.

- To ensure support for community based care programmes and easy access to good quality services

for those in need of such services.

- To ensure that all affected by AIDS receive proper care and treatment inside and outside the clinical setting with respect for the rights and dignity of each individual.

Strategies for Reduction of Impact

Counselling

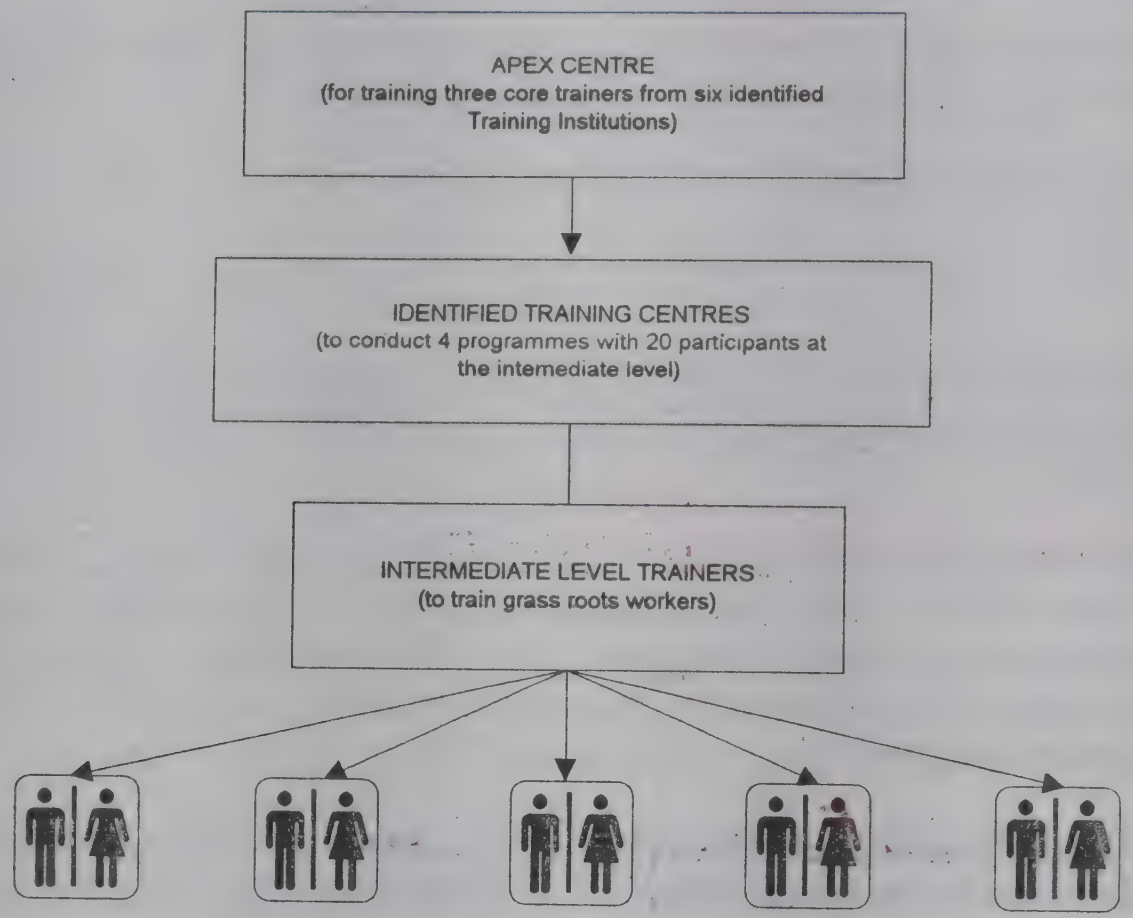
Counselling is face to face communication by which one can help the person to make decisions and act on them. It aims at preventing transmission of HIV infection and providing psycho-social support to those already affected.

Counselling is a helping process aimed at problem solving. It helps people to understand themselves better in terms of their own needs, strengths, limitations and resources they can avail of It brings about changes through a supportive relationship aiming to make the client independent through interpersonal contact along with opportunity to ask questions and to talk frequently. Prevention and support are complementary processes.

Counselling for HIV/AIDS is a new concept in India. There is a history of counselling activities associated with family planning, but never before has counselling for the prevention of a disease been so urgently required or so important. Setting up a comprehensive counselling support programme, including training of a wide variety of health care workers and social and community workers through standard training module and materials is an important aspect of the plans for this component.

NACO organized a national workshop with top counselling experts in the country, in February, 1993. In the week-long workshop, a rough outline of an STD/HIV/AIDS counselling training module was developed. This module is for use in training at Apex level, intermediate level and the grass-roots level The following figures outline the counselling dissemination strategy.

NACO Counselling Dissemination Strategy


APEX CENTRE
(for training three core trainers from six identified Training Institutions)
IDENTIFIED TRAINING CENTRES
(to conduct 4 programmes with 20 participants at the intermediate level)
INTERMEDIATE LEVEL TRAINERS
(to train grass roots workers)
Grass roots Workers

Tertiary Level (Skill Training)	Apex Centre (Core group of resources) 18 Trained Coordinators - 3 for each regional centre. 6 Regional Centres (N, NE, S, E, W, C) 6 Regional centers will train 480 intermediate level trainers - 80 each.
Secondary Level (Skill Practicing)	480 Intermediate Centres 480 Trainers/Counsellors will train 4800 grass roots level counsellors.
Primary Level (Skill Building)	Simultaneously - skill building will take place at peripheral centres.

These training modules were pre-tested and field tested by C.M.C., Vellore, and the Tata Institute of Social Sciences (TISS), Mumbai, in collaboration with NACO and WHO. Six regional centres, which are imparting training, with their statewise distribution, are described below:

East (CINI)	West Bengal, Bihar, Orissa, Andaman & Nicobar Islands and Sikkim.
South (CMC)	Tamil Nadu, Kerala, Andhra Pradesh, Karnataka, Pondicherry and Lakshadweep.
West (TISS)	Maharashtra, Gujarat, Goa, Madhya Pradesh, Dadra and Nagar Haveli, Daman and Diu.
North-East (VES)	Assam, Manipur, Meghalaya, Mizoram, Nagaland, Tripura and Arunachal Pradesh.
North (MAMC)	Delhi, Himachal Pradesh, Punjab, Haryana and Chandigarh
Central (National AIDS Research Inst., NARI, Pune)	Jammu & Kashmir, Rajasthan, Uttar Pradesh.

C.M.C., Vellore, an Apex centre has already trained 15 master trainers from the regional centres and of these, 5 regional centres, namely: East (Child in Need Institute, CINI, Calcutta), South (Christian Medical College, CMC Vellore), West (Tata Inst. of Social Sciences, TISS, Mumbai), North-East (Vivekananda Education Society, VES, Calcutta), North (Maulana Azad Med. College, MAMC, N. Delhi) are going to train intermediate level counsellor trainers in 20 programmes. The West Centre (TISS) has already trained 80 intermediate level trainers and identified the intermediate centres to train 800 grass-roots level counsellors. TISS has also started grass-roots level training. The other 4 centres are also going to start grass-roots level training within two months. All the intermediate centres are going to train 4800 grass-roots level trainers in 240 programmes at the end of one year of this counselling training project. These grass-roots level counsellors are going to perform peripheral level of counsellors. The duration of the training at the regional centres was one week and that of the grass-roots level training at the intermediate centres was of three days only.

Activities of the Counselling Training Project

1. Acquire skills on counselling for HIV/AIDS/STD,
2. Provide counselling services to the public as well as disseminate information on HIV/AIDS/STD,
3. Train volunteers and other on basic counselling on HIV/AIDS/STD,
4. Assist to initiate pilot programme with NGOs to develop nodal voluntary testing centres.

Monitoring of Training

A mechanism for monitoring the training programmes has already been developed with targets assigned to each level.

Strengthening Capacity of Counselling Centres

NACO is providing technical as well as financial support to organizations in conducting training and counselling on HIV/AIDS/STD. Wherever needed, it provides for skeletal staff, equipment and resources for smooth functioning of the centre. These centres have access to information on a continuous basis from the NACO.

Research

Research projects which were focussed in the area of counselling were initiated as well as supported by NACO These projects were contracted to institutes and organizations which were doing pioneering work in this field and were aimed at strengthening the knowledge required by the counsellors in their day-to-day operations.

Health Care Services

As people infected with HIV gradually develop HIV-related diseases and eventually AIDS, this will place an increasingly heavy burden on the health care system. Care for people with HIV and AIDS will often be provided in clinical settings where health care workers are not used to treating and managing such patients. Misconceptions regarding the infectivity of patients and fear of health care workers might adversely affect the quality of care provided. Unjustified calls for isolation of patients with HIV infection or AIDS might further constrain the potential for expansion of clinical services to deal with greater number of such patients, or it might lead to an actual reduction in the care services provided. It is, therefore, of importance that patients with HIV infection or AIDS are not segregated but are treated in regular wards.

The training of health care workers, in both the clinical and social-psychological aspects of AIDS and its impact on themselves and those in their care, is essential. Clinical Management includes training of medical and paramedical personnel as well as provision of treatment facility for opportunistic infections without any discrimination or isolation of the HIV infected.

Control of Hospital Acquired Infection

Hospital acquired infections are those which the inpatients or the personnel associated with the hospital acquire during their stay in the hospital. These infections are sometimes very resistant and not amenable to treatment. HIV has also proven to be an infection which can be acquired by using improperly sterilized needles or instruments. Taking this in view, NACO produced a booklet on guidelines on the control of hospital acquired infections, which were circulated to all State AIDS Programme Officers for further distribution to hospital/dispensaries. Later on, two modules were prepared for training of medical officers of the hospitals and for those at the primary health care level for control of infection. After thorough pre-testing at three centres - Delhi, Mumbai and Calcutta, a final version was produced which has been used for training over 800 personnel from West Bengal, Assam, Karnataka and Kerala, in two workshops conducted at Calcutta and Guwahati. Further training programs are in progress in most states.

Milestones

A complete training module in AIDS case management with emphasis on counselling has been completed and circulated.

- A training module and guidelines for Primary Health Care Physicians has been completed.

- RAK College of Nursing in collaboration with NACO and WHO has completed its comprehensive training manual for Nurses which will be used in both pre-service and in-service training.

- NACO has conducted 20 workshops in different Medical Colleges of the country and trained about 600 Professors, Assistant Professors and Lecturers on the clinical management and diagnosis of HIV/AIDS and basics of counselling.

- The Christian Medical Association of India (CMAI), in collaboration with NACO and WHO, trained 22 core trainers of trainers in clinical management, diagnosis and counselling for HIV and AIDS in August 1993. These trainers have received hands on training in Africa, and have now trained 1545 medical officers at district and hospital level through 51 workshops. Out of 465 districts, 429 have been involved so far, and is expected that eventually all will participate. During the third and fourth phases of training, it is planned to train medical officers at the primary health care level, with the help of these trainers.

- The IMA has undertaken training of private general practitioners. The training includes counselling, as well as case diagnosis and management.

- Nurses have been trained in four orientation training programmes organized by NACO in Delhi, Calcutta, Mumbai and Chennai.

Community Based Care

Even if all new cases of HIV infection could be prevented, the number of people with HIV infection (including AIDS) would continue to increase rapidly in the foreseeable future as individuals currently infected with HIV gradually become ill. Without advance planning, the needs of those people and their families will overwhelm health care systems and community resources.

AIDS patients and those with related illness can be taken care of in the home setting with proper support and backup from the community and local health facilities as shown in figure on the next page. As an individual becomes ill from AIDS or an AIDS-related illness, she/he will make the journey from home to the clinical setting a number of times. The many steps along this route from home via the community health workers and local clinic to the hospital need to be prepared and strengthened. The fears of health care and community workers need to be allayed with clear information and education.

In March 1994, a team from NACO, Oxfam and WHO travelled to Manipur to design a pilot programme on care and support, called the "Continuum of Care" Project. This initiative is a joint effort by WHO, NACO and NGOs to develop a care and support system, spanning health care networks, homes and the community. This has led to the development of generic guidelines for community care. Further pilot programmes are being planned in Maharashtra and Tamil Nadu.

Continuum of Care for Persons with HIV/AIDS

Clinical Management	•Appropriate diagnosis and treatment •Discharge planning for follow-up
Nursing Care	•Provide medical and palliative care •Ensure infection control practices •Educate family members, promote preventive behaviour and use of condoms
Counselling	•Make informed decision on HIV test •Reduce stress/anxiety •Plan for future, promoting positive living and behavioral change
Home Care	•Train family members •Provide care and moral support •Provide linkages to social welfare systems

CHANDRA BABU

Chandra Babu is 22 years old and lives with his parents and six brothers and sisters in Imphal. He has known he is HIV-positive for the past three years:

"When I began to hear about AIDS, I decided to go for the test. I realized that there was every possibility of me turning up positive. I had shared needles on many occasions. I did test positive and I tried not to feel too depressed about the way I had been living. Being part of a group that is helping other people like myself is giving me strength.

"Before I disclosed to the public that I was an ex-drug user, I had to think of the repercussions it would have on my father, my mother, my brothers and sisters. When I was alone, it was a personal problem, but once I was helped by the organisation, I didn't have to hide it anymore. My father objected. He said that now I had stopped using drugs, there was no need for me to mix with other ex-users. He wanted me to study further. But I felt that supporting SASO's (a partner NGO in continuum care project in Manipur) work was what I really wanted to do. It wasn't easy to get my father to understand. But now he can see that I am happy in the work I am doing and he has accepted me.

"I find it difficult it difficult to mix with friends who use drugs now and then. They have flippant attitudes and think that injecting drugs occasionally is all right. But for me, it would be back to addiction once again."

(Case study courtesy 'Broadening the Front' by Jaya Shridhar and Anthony Colaco)

Conceptual Framework of the Continuum Care Project

The following are the basic concepts of this intervention project as advocated by WHO.

- Comprehensive care,
- a continuum of care, linked with a referral system spanning home and hospital,
- integration of this model of care into the existing health care system,
- forging a close coordination and cooperation between NGOs and government health services,
- inclusion of a prevention component to care,
- utilization of traditional and alternative care patterns and available resources with provision for necessary sustainable support mechanisms.

The intervention itself includes training a core group of health workers in health facilities and NGO volunteers in the community on their relevant roles of comprehensive care and on available resources for care with social support in each specific area. The result of this training will then facilitate activities where people with AIDS receive appropriate care. The care providers will be in contact with relevant NGOs close to the homes of the patients through the use of volunteers from those organizations. They will continue to provide moral and psycho-social support, facilitate follow-up and referral whenever appropriate and facilitate home care by family members.

Specific Objectives

1. To stimulate the formation of core inter-disciplinary teams within health facilities responsive to PWA needs for comprehensive care and provide relevant training.

2. To train volunteers from the NGO core group to provide emotional and social support to PWAs, prepare families for giving home care, teach prevention techniques for HIV transmission and, when needed, refer PWAs to health facilities.

3. To develop a referral network linking health services with NGOs for the provision of care and prevention across the continuum thus created by making use of an appropriate resource directory of all care and social support available to PWAs in their environment.

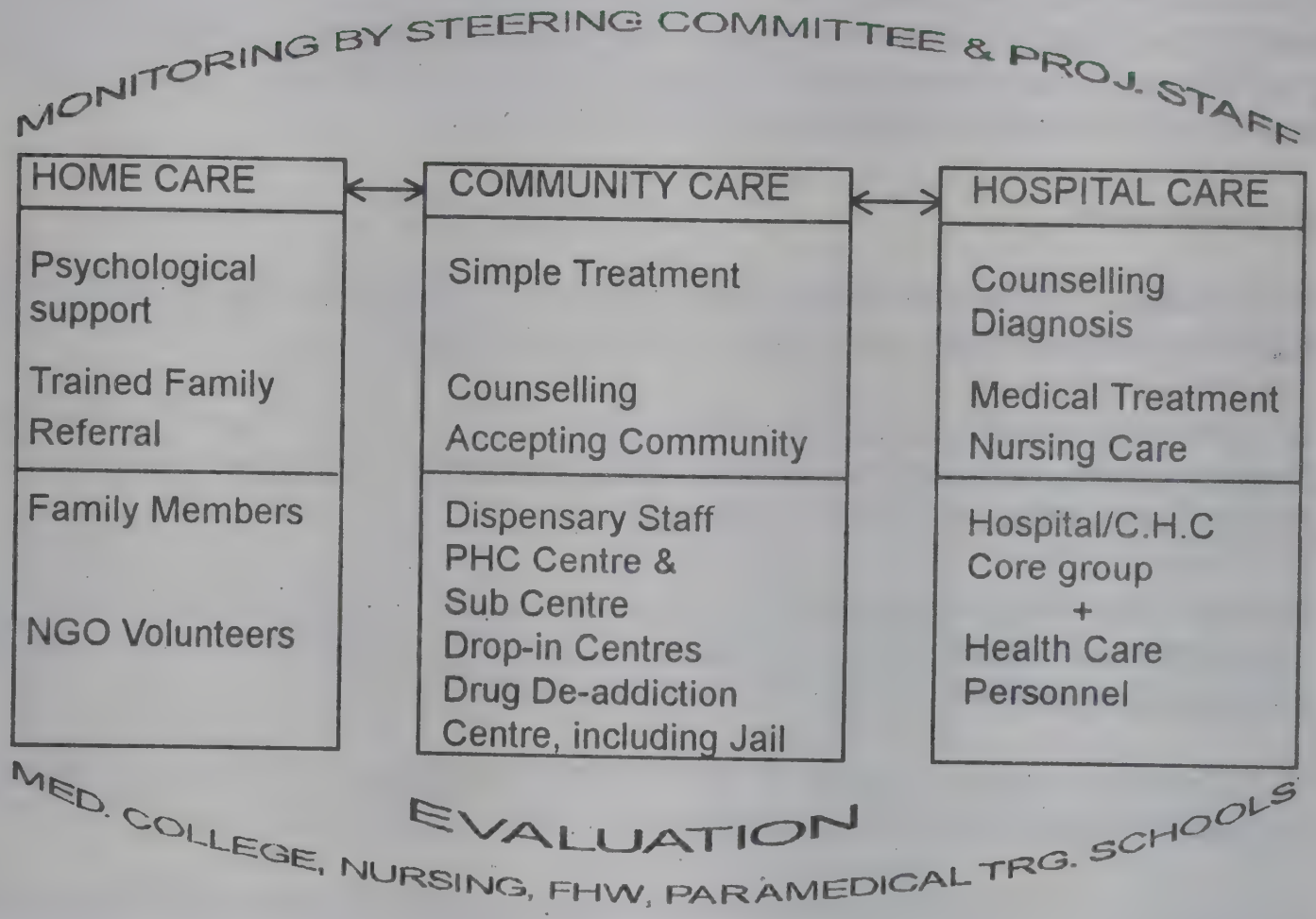
4. To develop and make available an appropriate culture specific AIDS Home Care Handbook for use in local languages, and document the process for replication in other areas.

5. To evaluate the process and compare specified process and outcome indicators before and after the intervention, eg., KABP of volunteers and health personnel, focus group discussions, etc.

These projects have led to training modules for health workers and community workers on care and support being developed; the process of adapting the WHO AIDS Home Based Care Handbook being documented; and a protocol for implementing community based care programming being developed for use in all states.

Seeing the success of the care continuum process in Churachandpur, Kakching and Imphal another project for care continuum has been taken up in Tamil Nadu and Maharashtra as they are the worst affected areas. They will follow the way Manipur has done. They will firstly train the home care counselling, nursing care and clinical management as stated earlier.

MANIPUR APPROACH: CONTINUUM OF AIDS CARE



PROGRAMME FINANCING

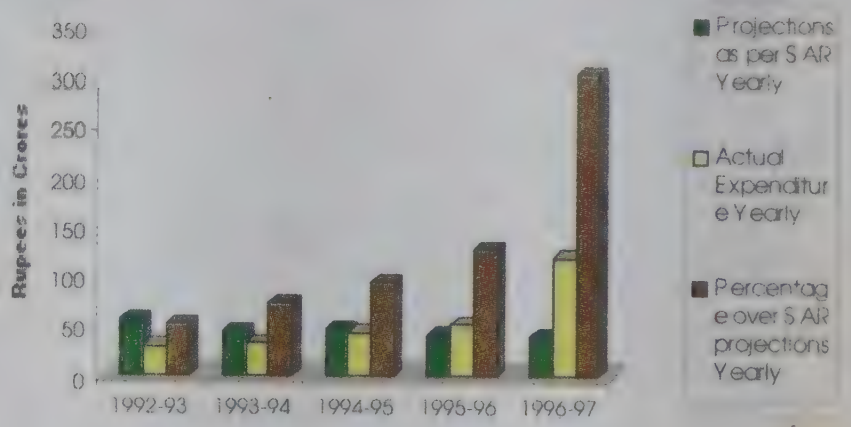
In recognition of the importance of the prevention and control of HIV/AIDS in India Government of India took initiative by establishing a dedicated wing in the Ministry of Health and Family Welfare, namely, National AIDS Control Organization (NACO) at the beginning of VIII Five Year Plan. This organization is spearheading the national response to develop overall policy guidelines, secure financial resources, set up infrastructure, build capacity in relevant fields and support national operational system with a broad based multisectoral strategy for combating the spread of infection.

At the national level, a National AIDS Committee and a National AIDS Control Board now also entrusted with the functions of Technical Advisory Committee are operational. National AIDS Control Organization is working with the States/Union Territories to develop appropriate solutions in terms of flow of funds.

Budget Utilization

National AIDS Control Project is being implemented with committed assistance of US Dollar 84 million from World Bank. NACO has utilized a cumulative sum of Rs.275.64 crores which is 121.31% of the projected utilization as per staff appraisal report (SAR) (Rs.227.22). A statement with the break-up of the projections of expenditure year-wise as per the World Bank Staff Appraisal Report and actual expenditure made year-wise by NACO and a bar graph of this information are given here.

Yearly projections & Actual Expenditure



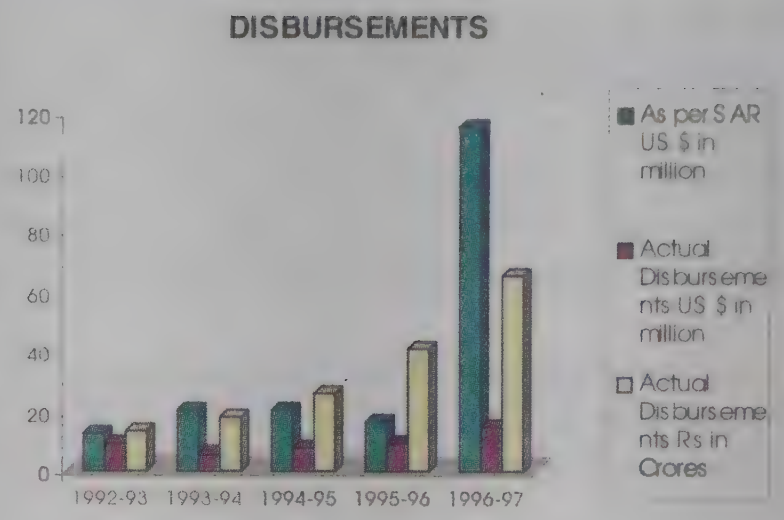
PROJECTED & ACTUAL EXPENDITURE (Rupees Crores)

Year	Projections (As per S.A.R.) Yearly	Projections (As per S.A.R.) Cumulative	Actual Expenditure Yearly	Actual Expenditure Cumulative	Percentage over S.A.R.Projections Yearly	Percentage over S.A.R.Projections Cumulative
1992-93	56.84	56.84	29.44	29.44	51.79	51.79
1993-94	44.61	101.45	32.65	62.09	73.19	61.20
1994-95	46.18	147.63	43.41	105.50	94.00	71.46
1995-96	40.47	188.10	51.26	156.76	126.66	83.34
1996-97	39.12	227.22*	118.88	275.64**	303.89	121.31

*This is excluding physical contingencies and price contingencies.
**Position of expenditure is estimated up to 31 March, 1997 and is based on final estimates.

This has been made possible due to remarkable improvement in idolization of funds by the States, viz., Andhra Pradesh, Assam, Himachal Pradesh, Haryana, Gujarat, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Manipur, Mizoram, Meghalaya, Nagaland, Rajasthan, Tamil Nadu, Uttar Pradesh, West Bengal, Delhi and some Union Territories without Legislature. Other States are also activating their machinery for utilizing their potential to make the programme successful.

The following table and bar graph depicts position regarding disbursement of IDA credit as compared to the projections in the staff appraisal report.



DISBURSEMENTS

Year	As per S.A.R. (US $ in Million)		Actual Disbursements (US $ in Million)		Actual Disbursements (Rupees in Crores)	
	Yearly	Cumulative	Yearly	Cumulative	Yearly	Cumulative
1992-93	12.20	12.20	8.88	8.88	13.04	13.04
1993-94	20.00	32.20	5.65	14.53	17.66	30.70
1994-95	20.40	52.60	7.66	22.19	25.86	56.56
1995-96	16.30	68.90	9.16	31.35	40.69	97.25
1996-97	15.10	84.00	14.92	46.27*	65.12	162.37

*Includes special account of US Dollar 5 million.

The reasons for slow disbursement are (i) slow pace of implementation by some states; (ii) delay in submission of reimbursement claims; (iii) fluctuation in exchange rate of US Dollar vis-a-vis Indian Rupee; and procedural delays in procurement of equipment for blood bank, blood component separation facilities and STD clinics.

In addition to the above, another factor which affected the utilization of funds was the delay in World Bank's approval to the Project. The program was, however, launched within two days of the agreement on 23rd Sept., 1992. Thus to offset this loss of time at the start of the Project extension has been sought so as to ensure that the momentum of the programme is sustained.

USAID assisted APAC Project in Tamil Nadu

AIDS Prevention and Control (APAC) Project in Tamil Nadu aims at tackling HIV transmission in the state of Tamil Nadu by reinforcing HIV prevention behaviour among population at risk to the infection notably commercial sex workers and their clients and STD patients.

The National AIDS Control Organization of the Ministry of Health and Family Welfare acting on behalf of the Govt. of India, and Voluntary Health Services, Chennai signed this tripartite agreement with USAID on 12th January, 1995 and the programme was started on 1st Feb., 1995. The period of this agreement is February 1, 1995 through January 31, 2002. The total estimated assistance under this agreement is US $ 10 million or say Rs. 30 crores . By the end of 31st March, 1997, Rs. 6.36 crores would have been placed with the VHS, Chennai. Out of this funds to the extent of Rs.1.86 crores have been utilized by VHS, Chennai.

WHO Regular and Extrabudgetary Resources in Support of the Government of India National AIDS Control Programme 1990-97

Period/Details	WHO Regular Country Budget Resources	WHO/Global Programme on AIDS Extrabudgetary Trust Fund Resources		Total (US $)
		Multilateral	Global undesignated	
1990-91				
- MOH&FW	525,850		515,000	1,040,850
(DGHS)			445,424	
- Maharashtra State			445,424	62,856
- Manipur State			62,856	
Total	**525,850**		**1,023,280**	**1,549,130**
1991-92				
- MOH&FW		245,985 (SIDA)		2,105,985
(DGHS/NACO)		1,860,000 (USAID)		
- Tamil Nadu State		247,021 (SIDA)	39,883	286,904
- West Bengal State		367,412 (SIDA)		367,412
- Delhi Union Territory		93,407 (SIDA)	48,961	142,368
Total		**2,813,825**	**88,844**	**2,902,669**
1992-93				
- MOH&FW (NACO)	306,200		2,417,603	2,723,803
HIV/STD Interven. project		542,495 (SIDA)		542,495
Total	**306,200**	**542,495**	**2,417,603**	**3,266,298**
1994-95				
-MOH&FW (NAC0)	323,900		1,546,850	1,870,750
-MOH&FW (" Tech. Asst.)			600,000	600,000
HIV/STD Interven. Project		542,495 (SIDA)		542,495
- Tamil Nadu State		82,809 (SIDA)		82,809
- West Bengal State		142,671 (SIDA)		142,671
Total	**323,900**	**767,975**	**2,146,850**	**3,238,725**
1996-97			Estimated	
Total	**522,500**	Not Available	**2,724,933**	**5,972,366**
G.Total	**1,678,450**		**6,254,660**	**7,933,110**

ANNEXES

GLOBAL DEVELOPMENT AND RESPONSES

AIDS and Human Rights

Discrimination against people with HIV infection or AIDS is still impeding efforts at prevention of the disease. Worldwide, the human rights of HIV infected people or people with AIDS (PWA) are being abused by governments and individuals alike. In addition to the HIV/AIDS epidemic, we face an epidemic of prejudice. Such discrimination can take many forms among which: quarantine; access to health care denied or reduced; access to housing denied; discrimination at workplace; interference with right to education; restrictions on freedom of movement; and compulsory testing/screening for HIV.

The World Health Assembly adopted in a resolution in May, 1992, which observes that there is no public health rationale for any measures that limit the rights of the individual, particularly measures requiring mandatory testing. The resolution calls upon member states to oppose discrimination against persons and specific groups known to be, or suspected of being, HIV infected. It is also pledged that member states could ensure a humanitarian response to HIV/AIDS so that public health is not undermined by discrimination and stigmatization.

Women and AIDS

Although a decade ago women and children seemed to be at the periphery of the epidemic, they are now the centre of concern. It is estimated that almost half of the newly infected adults are women. As infections in women rise, so do infections in the infants born to them. In many parts of the world, women have limited or no access to education or health care services. Gender inequalities in terms of social roles and customs ensure that women have often no control over sexuality, nor can they enforce condom use by their male partners. Poverty and lack of economic opportunity forces many women into prostitution, where they run an increased risk of being infected by male customers and being subsequently blamed for spreading the infection.

Strategies to reach women with IEC approaches, to provide accessible and acceptable services for STD care are being developed and implemented. But these efforts will have limited impact on the epidemic as long as gender inequalities are not addressed.

HIV Infections in Prisons

Prisons have been identified as a high risk environment for transmission of HIV either through sharing of needles by injecting drug users or through sexual contact. A survey of 55 prisons in 31 countries revealed that despite provision of information on HIV transmission a significant amount of transmission still takes place. Measures to prevent infection, such as provision of condoms, are rarely implemented

Following a WHO consultation on this subject, guidelines have been prepared which recommend that condoms be made available to prisoners if any possibility of sexual contact exist and that wherever prisoners inject drugs, prison services consider introducing needle exchange programmes or the provision of bleach to clean injecting equipment, provided such programmes also exist in the community at large.

Research for a Female Controlled Prevention Method

WHO has launched a new research strategy which it believes could revolutionize AIDS prevention efforts. This strategy, backed by a large number of representatives from research institutes, pharmaceutical companies and drug regulatory bodies, aims at the development of a safe antimicrobial agent (microbicide), capable of inactivating HIV in a woman's vagina, or of preventing the virus from attaching itself to the lining of the vagina. Ideally, this substance would also protect against common STDs.

Existing efforts to control the spread of HIV infection consist primarily of widespread condom promotion, the promotion of other, safer sexual practices and the control of other sexually transmitted diseases. Condoms are highly effective means of preventing HIV and STD, and condom use is increasing throughout the world. However, many women remain without protection against HIV, as they are often unable to control or negotiate safer sex, including the use of condoms.

Zidovudine (AZT) Reduces Vertical Transmission

An interim analysis of a phase III randomized, placebo controlled trial to evaluate the efficacy, safety and tolerance to AZT in preventing maternal-fetal HIV transmission has shown a highly significant reduction of the risk among women who received AZT.

The study conducted in 50 cities in the USA and 9 in France, revealed a rate of transmission in the placebo group of 25.5% while the rate in the AZT group was only 8.3%. This corresponds to a 67.5% relative reduction in risk of transmission.

ANNEX 2

LIST OF SURVEILLANCE CENTRES WHERE HIV TESTING FACILITIES ARE AVAILABLE

In States/Union Territories	
1. Andhra Pradesh	1. Department of Microbiology, Osmania College, Hyderabad 2. Department of Microbiology, S. V. Medical College, Tirupati 3. Department of Microbiology, Andhra Medical College, Vishakhapatnam 4. Instt. of Preventive Medicine, Hyderabad
2. Arunachal Pradesh	5. Distt. Hospital, Itanagar
3. Assam	6. Department of Microbiology, Guwahati Medical College, Guwahati
4. Bihar	
5. Goa	7. Department of Microbiology, Goa Medical College, Panaji
6. Gujarat	8. Department of Microbiology, B.J. Medical College, Ahmedabad
7. Haryana	9. Department of Microbiology, Medical College, Rohtak
8. Himachal Pradesh	10. Department of Microbiology, Indira Gandhi Medical College, Shimla
9. Jammu and Kashmir	11. Department of Immunopathology, Sher-e-Kashmir Institute of Medical Sciences, Srinagar 12. Department of Microbiology, Government Medical College, Jammu
10. Karnataka	13. Department of Microbiology, Bangalore Medical College, Bangalore 14. Department of Microbiology, Kasturba Medical College, Manipal
11. Kerala	15. Department of Microbiology, Medical College, Trivandrum
12. Madhya Pradesh	16. Department of Pathology, Gandhi Medical College, Bhopal 17. Chaitram Hospital and Research Centre, Indore
13. Maharashtra	18. Department of Microbiology, Seth G. S. Medical College, Mumbai 19. Department of Microbiology, J. J. Hospital, Mumbai 20. Slon Hospital, Mumbai 21. B. Y. N. Nair Hospital, Mumbai 22. Rajabari Hospital, Ghatkopar, Mumbai 23. B. J. Medical College, Pune 24. Department of Microbiology, Govt. Medical College, Nagpur 25. Civil Hospital, Kolhapur 26. Distt. Hospital, Chandrapur 27. Govt. Medical College, Miraj
14. Manipur	28. J. N. Hospital, Imphal
15. Meghalaya	29. Civil Hospital, Shillong
16. Mizoram	30. Civil Hospital, Aizwal
17. Nagaland	31. Naga Hospital, Kohima 32. Distt. Hospital, Dimapur
18. Orissa	33. Department of Microbiology, S. C. B. Medical College, Cuttack
19. Punjab	34. Govt. Medical College, Amritsar
20. Rajasthan	35. Department of Microbiology, S. M. S. Medical College, Jaipur

21. Sikkim	36. S. T. N. M. Hospital, Gangtok
22. Tamil Nadu	37. Chennai Medical College Hospital , Chennai 38. Department of Microbiology, Madurai Medical College, Madurai
23. Tripura	39. Distt. Hospital, Agartala
24. Uttar Pradesh	40. Department of Microbiology, K. G. Medical College, Lucknow
25. West Bengal	
26. Andaman and Nicobar Islands	41. G. B. Hospital, Port Blair
27. Chandigarh	
28. Dadra and Nagar Haveli	
29. Daman and Diu	
30 . Delhi	42. Department of Microbiology, University College of Medical Sciences, Shahdara, Delhi 43. Department of Microbiology, Maulana Azad Medical College, New Delhi
31. Lakshadweep	44. Government Hospital, Kavarati
32. Pondicherry	45. Government General Hospital, Pondicherry
Under Indian Council of Medical Research	
	46. Central JALMA Instt. for Leprosy, Agra 47. Regional Medical Research Centre, Bhubaneshwar 48. Regional Medical Research Centre for Tribal Health, Jabalpur 49. Tuberculosis Research Centre, Chennai 50. Rajendra Memorial Research Institute, Patna
Under Directorate General of Armed Forces Medical Services	
	51. Indian Naval Ship Hospital, Ashwini, Mumbai 52. Indian Naval Ship Hospital, Cochin 53. Armed Forces Command Hospital, Delhi Cantt. 54. Department of Microbiology, A. F. M. C. Pune 55. Indian Naval Ship Hospital, Kalyani, Vishakhapatnam
In Central Institutions	
	56. All India Institute of Hygiene and Public Health, Calcutta 57. Deptt. of Microbiology, JIPMER, Pondicherry
In Autonomous Institutions	
	58. Department of Microbiology, Instt. of Medical Sciences, Varanasi 59. Jawaharlal Nehru Medical College, Aligarh 60. Department of Immunopathy, P.G.I., Chandigarh 61. National Institute of Mental Health and Neurosurgery, Bangalore
In Private Institutions	
	62. Kamla Nehru Medical College, Allahabad

LIST OF HIV REFERENCE CENTRES

1. National Institute of Communicable Disease
   Delhi

2. All India Institute of Medical Sciences
   New Delhi

3. Indian Institute of Immunohematology
   Bombay

4. National Institute of Cholera and Enteric Diseases
   Calcutta

5. School of Tropical Medicines
   Calcutta

6. Madras Medical College
   Chennai

7. National AIDS Research Institute (NARI)
   Pune

8. Regional Medical College
   Imphal

9. Christian Medical College
   Vellore

The reference centres should be entrusted with the responsibility of carrying out confirmatory test. They should also be made responsible for diagnosis, quality control of HIV kits, guidelines for HIV testing, training in HIV testing and any other activity which may be necessary for standardization of HIV testing.

ANNEX 4

ZONAL BLOOD TESTING CENTRES IN THE COUNTRY

IN VARIOUS STATES/UNION TERRITORIES		
1.	Andhra Pradesh	1. Blood Bank, Gandhi Hospital, Hyderabad 2. Blood Bank, M.J. Cancer Hospital, Hyderabad 3. Blood Bank, Nizam's IMS Hyderabad 4. Blood Bank, Institute of Preventive Medicine, Hyderabad 5. Blood Bank, Govt. Headquarters Hospital, Vijayawada 6. Blood Bank, Govt. Headquarters Hospital, Karim Nagar 7. Blood Bank, Govt. Headquarters Hospital, Cuddapah 8. Blood Bank, Govt. Headquarters Hospital, Kammam 9. Blood Bank, Govt. Headquarters Hospital, Chittor 10. Blood Bank, Medical College, Tirupati 11. Blood Bank, Guntur Medical College, Guntur 12. Blood Bank, General Hospital, Kumool
2.	Arunachal Pradesh	13. Blood Bank, Government Hospital, Itanagar
3.	Assam	14. Blood Bank, Guwahati Medical College, Guwahati 15. Blood Bank, Medical College, Dibrugarh 16. Blood Bank, Medical College, Silchar
4.	Bihar	17. Blood Bank, Medical College, Gaya 18. Blood Bank, Patna Medical College, Patna 19. Blood Bank, District Hospital, Dhanbad 20. Blood Bank, District Hospital, Jamshedpur 21. Blood Bank, Jamshedpur 22. Blood Bank, Rajendra Medical College, Ranchi 23. Blood Bank, Medical College, Bhagalpur 24. Blood Bank, Shri Krishna Medical College, Muzzafarpur 25. Blood Bank, Medical College, Darbhanga
5.	Goa	26. Blood Bank, Medical College, Panaji 27. Blood Bank, Civil Hospital, Panaji
6.	Gujarat	28. Blood Bank, Surat Medical College, Surat 29. Blood Bank, Govt. Medical College, Vadodara 30. Blood Bank, B.J. Medical College, Ahmedabad 31. Blood Bank, M.P., Shah Hospital, Jamnagar 32. Blood Bank, District Hospital, Junagarh 33. Blood Bank, Civil Hospital, Amreli
7.	Haryana	34. Blood Bank, Medical College, Rohtak 35. Blood Bank, District Hospital, Hissar 36. Blood Bank, General Hospital, Faridabad 37. Blood Bank, General Hospital, Karnal
8.	Himachal Pradesh	38. Blood Bank, Indira Gandhi Medical College, Shimla 39 Blood Bank, District Hospital, Dharamsala
9.	Jammu and Kashmir	40 Blood Bank, Govt. Hospital, Srinagar 41. Blood Bank, Medical College, Jammu
10.	Karnataka	42. Blood Bank, K.C. General Hospital, Bangalore 43. Blood Bank, H.S.I.S. Hospital, Bangalore 44. Blood Bank, K.M. Instt. Of Oncology, Bangalore 45. Blood Bank, K.M.C. Hospital, Hubli 46. Blood Bank, Kasturba Medical College, Manipal 47. Blood Bank, Medical College, Bellari

		48. Blood Bank, Kasturba Medical College, Mangalore 49. Blood Bank, Medical College, Gulbarga 50. Blood Bank, Medical College, Belgaum
11.	Kerala	51. Blood Bank, Medical College Hospital, Calicut 52. Blood Bank, Govt. Hospital, Emakulum 53. Blood Bank, Medical College, Trivandrum 54. Blood Bank, District Hospital, Trichur 55. Blood Bank, District Hospital, Cannanore
12.	Madhya Pradesh	56. Blood Bank, Medical College, Bhopal 57. Blood Bank, Distt. Hospital, Ujjain 58. Blood Bank, Medical College, Gwalior 59. Blood Bank, D.H. Sagar 60. Blood Bank, Medical College, Indore 61. Blood Bank, Rewa Medical College, Rewa 62. Blood Bank, District Hospital, Bilaspur 63. Blood Bank, Medical College, Jabalpur 64. Blood Bank, District Hospital, Chindwara 65. Blood Bank, Medical College, Raipur
13.	Maharashtra	66. Blood Bank, K.E.M. Hospital, Mumbai 67. Blood Bank, L.T.M.G. Hospital, Mumbai 68. Blood Bank, B.Y.L. Nair Hospital, Mumbai 69. Blood Bank, Haffkine Institute, Mumbai 70. Blood Bank, Tata Memorial Hospital, Mumbai 71. Blood Bank, Red Cross, Mumbai 72. Blood Bank, Cooper Hospital, Mumbai 73. Blood Bank, Rajawadi Hospital, Mumbai 74. Blood Bank, J.J. Hospital, Mumbai 75. Blood Bank, General Hospital, Sollapur 76. Blood Bank, Govt. Hospital, Ulhasnagar 77. Blood Bank, Sasoon Hospital, Pune 78. Blood Bank, Govt. Medical College, Miraj 79. Blood Bank, Distt. Hospital, Chandrapur 80. Blood Bank, General Hospital, Kolhapur 81. Blood Bank, Medical College, Nagpur
14.	Manipur	82. Blood Bank, J.N. Hospital, Imphal
15.	Meghalaya	83. Blood Bank, Pasteur Hospital, Shillong
16.	Mizoram	84. Blood Bank, Government Hospital, Aizwal
17.	Nagaland	85. Blood Bank, Distt. Hospital, Dimapur 86. Blood Bank, Distt. Hospital, Muckchong 87. Blood Bank, Govt. Hospital, Kohima
18.	Orissa	88. Blood Bank, M.K.G.G. Hospital, Burla 89. Blood Bank, V.S.S. Medical college, Berhampur 90. Blood Bank, S.C.B. Medical College, Cuttack
19.	Punjab	91. Blood Bank, Shri Guru Tegh Bahadur Hospital, Amritsar 92. Blood Bank, Rajendra Hospital, Patiala 93. Blood Bank, Civil Hospital, Ludhiana
20.	Rajasthan	94. Blood Bank, S.M.S. Medical College, Jaipur 95. Blood Bank, Medical College, Ajmer 96. Blood Bank, Medical Colege, Bikaner 97. Blood Bank, S.N. Medical college, Jodhpur 98. Blood Bank, General Medical College, Udaipur 99. Blood Bank, Medical College, Kota

21.	Sikkim	100. Blood Bank, G.B. Hospital, Agartala
22.	Tamil Nadu	101. Blood Bank, Madras Medical College, Chennai 102. Blood Bank, Stanley Medical College, Chennai 103. Blood Bank, Kilpak Medical College, Chennai 104. Blood Bank, Govt. Royapettah Hospital, Chennai 105. Blood Bank, Apollo Hospital, Chennai 106. Blood Bank, Madurai Medical College, Chennai 107. Blood Bank, S.G. Hospital, Chennai 108. Blood Bank, Central Egmore, Chennai 109. Blood Bank, Govt. Hospital, Coimbatore 110. Blood Bank, Govt. Hospital, Salem 111. Blood Bank, Govt. Hospital, Tiruchirapally 112. Blood Bank, Medical College, Tiruneiveli
23.	Tripura	113. Blood Bank, G.B. Hospital, Agartala
24.	Uttar Pradesh	114. Blood Bank, District Hospital, Gorakhpur 115. Blood Bank, G.S.V. Medical College, Kanpur 116. Blood Bank, District Hospital, Allahabad 117. Blood Bank, K.L. Sharma Hospital, Meerut 118. Blood Bank, K.G.Medical College, Lucknow 119. Blood Bank, S.G.P.G.I., Lucknow 120. Blood Bank, Medical College, Agra 121. Blood Bank, District Hospital, Dehra Dun 122. Blood Bank, District Hospital, Nainital 123. Blood Bank, District Hospital, Shahjahanpur 124. Blood Bank, M.L.B. Medical College, Jhansi
25.	West Bengal	125. Central Blood Bank, Calcutta 126. Blood Bank, C.N.M.C.H., Calcutta 127. Blood Bank, N.R.S.M.C.H., Calcutta 128. Blood Bank, R.G.K.M.C.H., Calcutta 129. Blood Bank, S.S.K.M., Calcutta 130. Blood Bank, District Hospital, West Dinajpur 131. Blood Bank, North Bengal Medical College, Darjeeling 132. Blood Bank, District Hospital, Jalpalguri 133. Blood Bank, State Hospital, Burdwan
26.	Andaman and Nicobar Islands	134. Blood Bank, G.B. Pant Hospital, Port Blair
27.	Chandigarh	-
28.	Dadra and Nagar Haveli	-
29.	Daman and Diu	-
30.	Delhi	135. Blood Bank, G.T.B. Hospital, Shahdara, Delhi 136. Blood Bank, HIndu Rao Hospital, New Delhi 137. Blood Bank, LNJP/MAMC Hospital, New Delhi
31.	Lakshadweep	-
32.	Pondicherry	-
	UNDER INDICAN COUNCIL OF MEDICAL RESEARCH	
		138. Blood Bank, RMRC, Bhubneshwar 139. Blood Bank, Institute of Pathology, New Delhi

UNDER DIRECTOR GENERAL OF ARMED FORCES MEDICAL SERVICES	
	140. Blood Bank, Command Hospital, Bangalore 141. Blood Bank, Command Pathology Lab, Eastern Command, Calcutta 142. Blood Bank, Armed Forces Command Hospital, Delhi Cantt. 143. Blood Bank, Command Pathology Lab, Central Command, Lucknow 144. Blood Bank, Armed Forces Medical College, Pune 145. Blood Bank, Command Hospital, Northern Command, Udhampur
IN CENTRAL INSTITUTIONS	
	146. Blood Bank, Lady Hardinge Medical College, New Delhi 147. Blood Bank, Blood Transfusion Services, Safdarjung Hospital, New Delhi 148. Blood Bank, JIPMER, Pondicherry 149. Blood Bank, RML Hospital, New Delhi
IN AUTONOMOUS INSTITUTIONS (Other than ICMR)	
	150. Blood Bank, Medical College, BHU, Varanasi 151. Blood Bank, AIIMS, New Delhi 152. Blood Bank, Indian Red Cross Society, New Delhi 153. Blood Bank, PGI, Chandigarh
IN PRIVATE INSTITUTIONS	
	154. Blood Bank, Christian Medical College, Vellore

CLINICAL CASE DEFINITION FOR AIDS IN ADULTS IN INDIA (NACO)

AIDS in an adult is defined as who has:

a. Positive test for HIV antibody detected by two separate tests using two different antigens,
and
Any one of the following criterion:

1 (a) Weight loss of > 10% body weight or cachexia.
(b) Chronic diarrhoea of > one month duration of chronic cough > 1 month duration.
2. Disseminated, miliary or extra-pulmonary tuberculosis.
3. Neurological impairment restricting daily activities.
4. Candidiasis of the oesophagus diagnosable.
Dysphagia (odynophagia) along with oral candidiasis.
5. Kaposi's sarcoma.

Clinical stage progression:

Stage I HIV infection - asymptomatic
Stage II HIV-related disease - symotomatic
- Pulmonary tuberculosis
- Thrombocytopenia

Stage III Advanced HIV/AIDS

Clinical case definition for AIDS in children in India (NACO)

Paediatric AIDS is suspected in an infant or child presenting with at least two major signs associated with at least two minor signs in the absence of known cases of immuno-suppression.

Major signs:

a. Weight loss or abnormally slow growth,
b. 1. Failure to thrive;
2. Recurrent/persistent diarrhoea of over one month duration;
3. Recurrent bacterial infections, e.g., lower respiratory infections
4. Recurrent fever of over one month duration

c. 1. Candidiasis
2. Tuberculosis
3. PGL
4. Herpes zoster (HZ)

Minor signs:

a. Generalized Lymphodenopathy
b. Oropharyngeal candidiasis
c. Repeated common infections (otitis, pharyngitis, and so forth)
d. Persistent cough for over a month
e. Generalized dermatitis
f. Confirmed maternal HIV infection

OPPORTUNISTIC INFECTIONS AND MALIGNANCIES REPORTED IN AIDS IN INDIA (3200 CASES)

Infection / Malignancy	No. Of Cases	%age
Mycobacterium Tuberculosis (pulmonary and extrapulmonary)	1992	62.25
Candida albicans (oral and oesophageal)	1816	56.75
Cryptosporadium	902	28.18
Cytomegalo virus	96	3.00
Toxoplasma gondii	137	4.28
Cryptococcal meningitis	173	5.40
Pneumocystis carinii pneumonia (PCP)	104	3.25
Other parasitic infections, viz., amoebiasis, giadiasis, strongiloidosis	286	8.93
Herpes zoster	252	7.87
Lymphoid interstitial pneumonia (LIP)	14	0.30
Fulminating septicemia (FSC)	21	0.65
Nephrotic syndrome (NPHS)	2	0.06
Seborrhea	12	0.37
Cirrhosis	11	0.34
Pyogenic meningitis (PYM)	23	0.71
Others		
Kaposi's sarcoma	13	0.40
Non Hodgkin's lymphoma (NHL)	22	0.68
AIDS dementia complex	284	8.87
Persistent generalized lymphadenopathy (PGL) syndrome	900	28.12
Gullien Barre syndrome	10	0.31
Oral hairy leukoplakia	96	3.00
Total	**3200**	

ANNEX 7

LIST OF NACO PUBLICATIONS

1. Training Module on the Sentinel Surveillance of HIV Infection
2. Prevention and Control of HIV & AIDS: Manual for Health Care Workers
3. Specifications on Equipment Concerning Blood Banks, Blood Component Separation Units, STD Reference Laboratories & STD Clinics
4. AIDS Education in School: A Training Package
5. Management of STD Patients: Training Module
6. Reference Manual for Laboratory Workers: Diagnosis of STD
7. Strengthening Institutional IEC Capacity in States/Union Territories for AIDS Prevention and Control in India
8. AIDS in India - NACO News Letters
9. HIV & AIDS: Prevention, Care and Control, Self Instructional Modules for Pre-service and In-service Training of Nurses and Midwives (Module Eleven)
10. Prevention and Control of AIDS: Clinical Management Module
11. Training Module on HIV Infection for Medical Officers of PHC
12. Training Module for Medical Officers on Blood Transfusion
13. Administrative Guidelines for blood Transfusion Services
14. Standard for Blood Banks and Transfusion Services
15. National Guide Book for Blood Donor Motivators
16. Technical Manual - Transfusion Medicine
17. Training Modules on Blood Transfusion for:
    - i) Blood Bank Medical Officers - Part I and Part II
    - ii) Blood Bank Lab. Technologists
    - iii) Blood Bank Key Trainers

iv) Blood Bank Social Workers, Clinical Staff, Nursing Staff, etc.
v) Preparation of Blood Components

18. Guidelines for the Appropriate Use of Blood

19. Training Modules on Prevention of HIV Transmission in Hospitals

20. Simplified STD Treatment Guidelines

21. STD Treatment Recommendations

22. National AIDS Control Programme: Country Scenario Annual Updates

23. Hospital Acquired Infections: Guidelines for Control

24. Guidelines for the Involvement of NGOs in National AIDS Control Programme

25. Revised Guidelines for the NGOs for Collaboration on HIV & AIDS Programme

26. A Guide for the State AIDS Control Programme Managers for Collaboration on HIV/AIDS Programme

27. Guidelines for Planning HIV/AIDS Interventions in the Community

28. Guidelines for Planning Continuum of Care for People Living With HIV/AIDS

29. HIV/AIDS/STD Counselling Training Manual

30. AIDS Education for Student Youth (3rd revised edition)

31. Communicating about STDs/AIDS: How to Adapt, Develop and Use IEC Materials

32. Training Manual on IEC Planning for State AIDS Programme Officers

33. Revised Simplified STD Treatment Guidelines

34. Revised STD Treatment Recommendations

35. National HIV Testing Network: Operational Guidelines

36. Generic IEC Package for use in Commercial Sex Industry

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Supported by UNAIDS